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ONTARIO

PROVINCE OF ONTARIO

Commission and Committee of Inquiry

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Wednesday January 29, 1964

1964

VOLUME

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DATE

January 29, 1964



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SUBMISSION OF THE ONTARIO PODIATRY ASSOCIATION

1118

Appearances: Dr. W.A. Laine
Mr. Kenneth Mackay
Dr. Norman Gunn
Mr. D. Ogley, G.C.

SUBMISSION OF THE CANADIAN HEALTH INSURANCE
ASSOCIATION

1136

Appearances: G.R. Berry
A.H. Jeffery, G.C.
G.N. Watson
Dr. J.C. Emmett
Gordon L. Denny

SUBMISSION OF THE ONTARIO MEDICAL ASSOCIATION

1232

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MR. A. BOY COULTER

DR. R.J. SALLOWAY

DR. JOHN HAMILTON

MR. E.W. HOLAN

MISS HELEN MCARTHUR

MR. F.J. MULHOONEY

MR. GAWAN A. NAYLOR

MR. HARRY SIMON

MR. J.L. WHITNEY

MR. GLEN SIMPSON

Secretary



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VERBATIM REPORTING
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TORONTO, ONTARIO
TORONTO, ONTARIO

Toronto, Ontario
Wednesday, January 29th, 1964

PROVINCE OF ONTARIO

MEDICAL SERVICES INSURANCE ENQUIRY

---Upon commencing at 10:00 a.m.

Proceedings of the Public
Hearings held at the Gal-
braith Building, University
of Toronto, Toronto, Ontario
at 10:00 a.m. on Wednesday,
January 29th, 1964.

MR. LAINE: Yes.

MEMBERS OF ENQUIRY:

DR. J. GERALD HAGEY -- Chairman

MRS. J.A. AYLEN

DR. WILLIAM BUTT

SUBMISSION OF THE ONTARIO PODIATRY ASSOCIATION

MR. DALTON J. CASWELL

MR. A. ROY COULTER

DR. R.J. GALLOWAY

DR. JOHN HAMILTON

MR. W.S. MAJOR

MISS HELEN McARTHUR

MR. P.J. MULROONEY

MR. CARMAN A. NAYLOR

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MR. GLEN SIMPSON -- Secretary

* * * * *



PROVINCE OF ONTARIO

MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public
Hearings held at the Gal-
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at 10:00 a.m. on Wednesday,
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MEMBERS OF ENQUIRY:

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MRS. J.A. AYLEN

DR. WILLIAM BUTT

MISS A. REID

MR. DAWTON J. CASWELL

MR. A. ROY COULTER

DR. R.J. GALLOWAY

DR. JOHN HAMILTON

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MISS HELEN McARTHUR

MR. F.J. MULLOONEY

MR. GARMAN A. NAYLOR

MR. HARRY SIMON

MR. J.L. WHITNEY

MR. GLEN SIMPSON - Secretary



VERBATIM REPORTING
TORONTO SERVICE
TORONTO, ONTARIO

1119

Toronto, Ontario
Wednesday, January 29th, 1118
1964

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with governs the practice of podiatry in Ontario, and recognize

/AG/rps 2 ---Upon commencing at 10:00 a.m.

five colleges, and they are all located in the United States.

At present we are attempting to work on having a

4 THE CHAIRMAN: Gentlemen, I assume that you are
colleges in Canada, but as yet it has not come through.
5 the delegation from the Ontario Podiatry Association?

The entrance requirements of these approved

6 MR. LAINE: Yes.

colleges are two years pre-professional college study in English,

7 THE CHAIRMAN: And I gather that you have
chemistry, physics, biology, and the general pre-medical subjects.

8 had an opportunity to read the statement of instructions there,

Grade XIII in Ontario is accepted as equivalent

9 so in accordance with that, if your spokesman will introduce

10 to the first year of college. The professional course consists

himself and his colleagues, you may proceed.

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11 SUBMISSION OF THE ONTARIO PODIATRY ASSOCIATION
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13 Dr. Norman Gunn Mr. D. Ongley, Q.C.

14 does make in his particular field is receiving growing recogni-

15 DR. LAINE: My name is W.A. Laine, D.S.C.,
tion, especially in hospital service. This, I think, is pointed

16 from Toronto; to my left is Norman Gunn, D.S.C. from Weston;

17 up in the growing expansion in services we are providing at St.

18 Ken Mackay, Executive Director of the Association; and to my

19 Joseph's Hospital, St. Michael's Hospital, Toronto General

20 right is our legal counsel, David J. Ongley, Q.C., from Toronto.

21 Hospital, Baycrest Hospital and Toronto Western Hospital, and

22 Now, I'll just touch on a few points in the

23 we've had requests from other hospitals.

24 submission that will be significant.

25 With regard to our services in the hospitals,

26 First of all, podiatry is the treatment of any

27 Dr. Crowther, who is Head of the Diabetic Section of the Toronto

28 ailment, disease, defect or disability of the human foot, and

29 General, said that we just don't see these problems of infection

30 the podiatrist, by his specialized training in foot health is

31 and severe gangrene any more. This is simply being eliminated.

32 the only practitioner in the healing arts who exclusively deals

33 and this is because of the simple qualitative care we can provide

34 with foot health problems of the public.

35 reducing the need for people to be in hospital on their heels.

Our educational qualifications are on page 4, set



Toronto, Ontario
Wednesday, January 29th, 1964
1118

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SUBMISSION OF THE ONTARIO PODIATRY ASSOCIATION

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DR. LAINE: My name is W.A. Laine, D.S.C.,
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1 out by the Ontario Board of Regents, the Chiropody Act, 1944,
2 with governs the practice of podiatry in Ontario, and recognizes
3 five colleges, and they are all located in the United States.

4 At present we are attempting to work on having a
5 college in Canada, but as yet it has not come through.

6 The entrance requirements of these approved
7 colleges are two years pre-professional college study in English,
8 chemistry, physics, biology, and the general pre-medical subjects.

9 Grade XIII in Ontario is accepted as equivalent
10 to the first year of college. The professional course consists
11 of four years totalling approximately 4,500 hours, of which
12 3,000 are didactic and 1,500 are clinical.

13 The contribution that the podiatrist can and
14 does make in his particular field is receiving growing recogni-
15 tion, especially in hospital service. This, I think, is pointed
16 up in the growing expansion in services we are providing at St.
17 Joseph's Hospital, St. Michaels Hospital, Toronto General
18 Hospital, Baycrest Hospital and Toronto Western Hospital, and
19 we've had requests from other hospitals.

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23 and severe gangrene any more. This is simply being eliminated,
24 and this is because of the ample palliative care we can provide.
25 Reducing the need for people to be in hospital on that basis.



1 The studies have indicated that 70 to 80% of
2 the elderly have foot problems, and they tend to withdraw, and
3 become old rocking chair types. These people must move about.
4 If poor health makes them homebound, significant medical, socio-
5 economic and psychological disadvantages ensue and they become
6 family and public charges, with deleterious impact on the family
7 and society at large.

8 Foot problems afflicting the aged stem not only from
9 a lifetime of foot abuse, but also from pathological changes
10 involved in the process of aging. Along with gradual slowing
11 of metabolism, atrophy and degeneration have come the problems
12 of arterio sclerosis with its narrowing and hardening of blood
13 vessels and increasingly poor circulation. This gives rise to
14 pain on walking, cold feet, night cramping, numbness and blood
15 deficiency ulcers. Ulceration and gangrene incidence can be
16 reduced by proper foot care.

17 This is especially the case among diabetics
18 where podiatric care has resulted in a definite reduction in
19 amputations. This has been confirmed by reports from many
20 hospitals throughout the North American Continent. Amputation
21 of limbs was once not uncommon amongst people with circulatory
22 and similar problems. Now it is no longer a problem.

23 Now, foot care also plays a strong part in improv-
24 ing the standing and walking balance of patients with musculo-
25 skeletal problems, such as rheumatoid arthritis, people with



The studies have indicated that 70 to 80% of



1 paralysis and spastic conditions.

2 To keep these people ambulatory is a cost-saving
3 factor for the country, for the taxpayer.

4 The mental patient of course, is no exception to
5 these requirements of foot care, in fact, foot pain or
6 discomfort may aggravate his primary condition and retard
7 acceptance of rehabilitative measures.

8 This is another field that is extremely important.
9 In industry, foot fatigue is a real troublemaker. In business
10 and industry millions of dollars yearly are lost and product-
11 ivity declines, and a worker handicapped by sore or painful
12 feet, is not only less productive and probably accident-prone,
13 but fatigue and irritation resulting from foot discomfort are
14 often reflected in ill-temper towards others and inability to
15 enjoy daily activity.

16 Dr. Walter C. Alvarez of the Mayo Clinic back
17 in 1961 pointed out that the podiatrist keeps the patient
18 ambulatory and reduces costs from over four dollars daily for
19 the bedridden, to less than two dollars for the ambulatory.

20 These are 1950 figures, and my understanding
21 from the Hospital Services Commission, or some of the members,
22 is that the cost is something like thirty dollars a day for
23 keeping the patient in the hospital.

24 This saving, indeed, is greater today and with
25 the constant rise in cost of medical care, this becomes an important



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These are 1950 figures, and my understanding

is that the cost of keeping a patient in bed is still over four

dollars daily, and the cost of keeping a patient ambulatory is

less than two dollars daily.

This is a very important factor in the cost of medical care.

It is a factor that should be considered in any study of the



1 contributing factor in the care of patients.

2 Now, in the United States, 65% of the podiatrists
3 have been participating doctors in plans known as Blue Cross
4 and Blue Shield for a number of years, and it has not been
5 found necessary to raise rates when patients covered by
6 contracts for medical service may elect a podiatrist to perform
7 the service. We have of course letters from States such as
8 Illinois and New Mexico, New York, Michigan, Ohio, California,
9 Oklahoma, all stating that podiatry is included in these Blue
10 Shield plans. This is similar to some of the physician-
11 sponsored plans in Ontario, and in not one case have the
12 premium rates been raised for this service.

13 There has been talk in the newspapers and so
14 forth that this is an additional service. This is not an
15 additional service. These services are already called for in
16 the schedule of fees and the schedule of compensable services,
17 and I want to make it very clear that this is not an additional
18 service. It's merely giving the patient the choice as to whom
19 they wish to go to to have these conditions treated.

20 This does not raise the actuarial costs.
21 The podiatrist makes no claim for recognition of services not
22 already included in the insurance contract. It is the insur-
23 ance carrier itself who has established the list of compensable
24 services for which benefits are payable for services provided.

25 Now, the legislation in the province has clearly



1 contributing factor in the care of patients.
2 Now, in the United States, 5% of the podiatrists
3 have been participating doctors in plans known as Blue Cross
4 of Alabama. The plan is a health maintenance organization
5 which is a type of health insurance plan. It is a type of
6 contract for medical services may be a podiatrist to perform
7 the service. We have of course letters from States such as
8 Illinois and New Mexico, New York, Michigan, Ohio, California,
9 Oklahoma, all stating that podiatry is included in these Blue
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23 ance carrier itself who has established the list of compensable
24 services. Now, the legislation in the province has clearly



1 set forth the various individuals who shall be authorized to
2 treat and prescribe for the human body. In some instances the
3 right to treat is limited to certain parts of the human body
4 while in other instances it may be a complete licence. But in
5 either case the right is clearly established and is susceptible
6 of definition.

7 The argument often used by carriers that the
8 premium charged did not contemplate such services is not well
9 taken. The construction of rates for these contracts is based
10 upon reimbursable benefits for conditions and not for who shall
11 treat. Payment for the condition must have been contemplated
12 if the condition is listed in the schedule of compensable
13 services.

14 Now, podiatry does not contend that carriers must
15 include benefits for foot conditions in contracts written.
16 If they choose to sell policies that exclude such benefits, this
17 would be within their rights, and all practitioners of the
18 healing arts would then fare the same.

19 However, if reimbursement for foot conditions
20 is contained in the policy, then the carrier must recognize the
21 right of any licensed practitioner to treat, if so selected
22 by the policyholder.

23 In addition, I feel the podiatry profession,
24 with their specialized techniques can, with regard to minor
25 surgical procedures reduce hospital stay for patients. These



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1 conditions can be treated very adequately in the office. They
2 don't have to go and stay in the hospital two, three, four
3 days, maybe a week, taking up hospital space. These procedures
4 can very nicely be carried out in the office, and we have
5 estimated anywhere up to possibly half a million dollars could be
6 saved a year on this factor alone for the people of Ontario.

7 In conclusion, our main recommendation is that
8 Clause (1) of Section I of the Medical Services Insurance Act
9 be amended by adding thereto the following:

10 "For the purposes of this Act, the
11 "term 'physician' shall include a podiatrist
12 "registered and performing podiatric services
13 "under The Chiropody Act, Ontario, 1944."

14 This is the context of our brief, and we would
15 be very happy to answer any questions that you may have.

16 THE CHAIRMAN: Thank you. There are some members
17 of the Enquiry who have indicated a desire to ask some questions
18 of you. Miss McArthur?

19 MISS McARTHUR: Mr. Chairman, I'm not sure that
20 the delegation is aware that we heard some members of their
21 group in Windsor, and I went back and read that hearing.

22 I might ask for confirmation, on page 2, which
23 is really your summary, the last statement of your brief, I was
24 wondering whether the group had thought that there would be
25 other practitioners who might place themselves in a similar



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24 wondering whether the group had thought that there would be
25 some further action on this matter.



1 category, or do you consider yourselves unique in relation to
2 it? That you have special reasons why this group might be
3 included, other than other types of practitioners?

4 DR. LAINE: Well, first of all I don't think we
5 are in a position to speak for other groups. This pretty well
6 eliminates that factor. We can express opinions on that, but
7 really we're in no position to express what their position is.
8 We can only express our own position, and we are going by
9 previous experience elsewhere in Blue Shield and other plans in
10 the United States, and the experience has been that it has cover-
11 ed our profession along with medicine and osteopathy.

12 MISS McARTHUR: In requesting this, you are in
13 no way -- the wording could be read one or two ways, and I think
14 the group in Windsor indicated that you were in no way request-
15 ing the use of the word physician for your group?

16 DR. LAINE: I think the words say "for the
17 purposes of this Act". This eliminates that. That's merely
18 taken from the existing Blue Shield plans in the United States.
19 This is the way they term it. As a matter of fact it is stated in
20 the Michigan Blue Shield plan:

21 "For the purpose of this certificate,

22 "a podiatrist, as defined in Act 115 Public Acts

23 "Michigan 1915 as amended and licensed thereunder

24 "will be deemed to be a 'physician' as above

25 "defined in subdivisions (K) and (L) of this



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1 "Section, if and to the extent that he shall
2 "render services which he is legally qualified
3 "to perform under said Act and for which a
4 "fee is scheduled in the fee schedule of Blue
5 "Shield."

6 MISS McARTHUR: I think that answers my question.

7 On page 5, I had a little difficulty with the word medical
8 in the last paragraph. When you speak of medical teachers, are
9 you speaking of podiatrists, or are you speaking of bringing
10 in the medical profession in your teaching program?

11 DR. LAINE: No, they are already there. Are
12 you asking if they are medical practitioners?

13 MISS McARTHUR: Are they physicians? When you
14 speak of medical teachers?

15 DR. LAINE: Yes, that's right, that's right.

16 MISS McARTHUR: And attached to medical colleges?

17 DR. LAINE: That's right.

18 MISS McARTHUR: You are again talking about
19 colleges, the practice of medicine in general?

20 DR. LAINE: That's right. In other words, many
21 of these instructors are teaching at the medical school, at
22 the dental school, and in the podiatry school, because they are
23 usually in the same area. I'm speaking of Cleveland, for
24 instance. This is the case. The instructors overlap.

25 MISS McARTHUR: On page 7, I had a little difficulty

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1 with the word technically on the last part of the paragraph:

2 "The podiatry clinic at St. Joseph's

3 "Hospital is technically under the orthopaedic

4 "service ---"

5 What do you mean by technical?

6 DR. LAINE: Well, this is a quote from Dr.

7 Pennal, and by this I mean, or he means I assume that when

8 this clinic was originally started it was started as part of

9 the Orthopaedic Service Department. Well, now it functions in

10 that we take care of patients from all departments, and not

11 really under the Orthopaedic Service Department.

12 MISS McARTHUR: But you would work under the

13 supervision in these areas of the Orthopaedic Department?

14 DR. LAINE: No, they work under their own

15 supervision. I'm just informed -- I don't particularly attend

16 St. Joseph's, and it doesn't even function on the same day

17 now as it did originally, apparently, but it doesn't any

18 longer -- in other words, it's a separate department, just

19 as dermatology and allergy, and so forth.

20 I hope I answered your question.

21 MISS McARTHUR: Yes, I get the point. On page

22 14 you say:

23 "However, if reimbursement for foot

24 "conditions is contained in the policy, ---"

25 Do you mean all foot conditions, or only those



1 with the word technically on the last part of the paragraph:

2 "The podiatry clinic at St. Joseph's

3 "Hospital is technically under the orthopedic

4 "service ---"

5 What do you mean by technical?

6 DR. LAINE: Well, this is a quote from Dr.

7 Pennell, and by this I mean, or he means I assume that when

8 the orthopedic service is organized, it is organized to

9 take care of the orthopedic service, and the podiatry

10 service is organized to take care of the podiatric

11 service, and the orthopedic service is organized to

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26 service, and the orthopedic service is organized to



1 services that the podiatrist is licensed to render? It's
2 rather a sweeping statement, and I wondered if ---

3 DR. LAINE: Well, what we're speaking of there
4 is whatever foot conditions are contained in the policy that's
5 written. This has nothing to do with the podiatrist in that
6 sense.

7 In other words, if the policy that the insur-
8 ance company puts out, or whatever carrier it happens to be,
9 states that it's not all foot conditions, only ingrown toenails
10 will be covered, this is fine, and everybody fares the same
11 then.

12 MISS McARTHUR: So, you are really saying that
13 the podiatrist should be permitted to function in relation to
14 what he's qualified to do, but you aren't delineating that
15 he shall or shall not do such and such?

16 DR. LAINE: No, his practice Act covers that.
17 This is merely for the purposes of the policy.

18 THE CHAIRMAN: Dr. Butt?

19 DR. BUTT: Very briefly, you mention every-
20 thing but the foot. Where does the foot end?

21 DR. LAINE: Well, I think it's generally accepted
22 that it ends at the ankle joint.

23 DR. BUTT: And you mentioned such conditions
24 as diabetes, osteo-arthritis and so on.

25 What about hip dislocations? Is this within your



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20 that it ends at the ankle joint.

21 DR. BUTT: And you mentioned such conditions

22 as diabetes, osteo-arthritis and so on.

23 What about hip dislocations? Is this within your



1 sphere?

2 DR. LAINE: We don't treat the hip condition,
3 but we treat the local manifestation of it in the foot.
4 For instance, if they have an ulceration on the bottom of the
5 foot, this is what we would treat. We would not treat the
6 athero-sclerosis. This would be in conjunction with the medical
7 team.

8 DR. BUTT: In other words, you can't isolate
9 the foot from the rest of the body?

10 DR. LAINE: Oh, no.

11 DR. BUTT: The other thing, there are several
12 letters in here where you say this department and that depart-
13 ment of the General Hospital, the Western, and so on?

14 DR. LAINE: That's right.

15 DR. BUTT: And then you made a statement, did you,
16 that you aren't under the jurisdiction of the doctor there,
17 or a doctor?

18 DR. LAINE: That's right.

19 DR. BUTT: You aren't?

20 DR. LAINE: No. In other words when a patient
21 comes into the out-patient clinic, he has to go through the
22 medical clinic first. This is true for all departments. From
23 there they refer the patient to the respective department. When
24 they come to our department we handle them as we see fit.

25 THE CHAIRMAN: To some extent then you are under



DR. LAINE: We don't treat the hip condition,

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that you aren't under the jurisdiction of the doctor there,

or a doctor?

DR. LAINE: That's right.

DR. BUTT: You aren't?

DR. LAINE: No. In other words when a patient

they come to our department we handle them as we see fit.

THE CHAIRMAN: To some extent then you are under



1 the direction of the physician, in that it's on a referral basis?

2 DR. LAINE: Yes, just like all the other
3 departments are.

4 DR. BUTT: Do you feel that you have an autonomous
5 department separated from medical jurisdiction, from a medical
6 director over it?

7 DR. GUNN: In fact, everyone has a workup first
8 by the physician, but for the particular foot problem he is send-
9 ing it to our clinic for treatment.

10 DR. BUTT: And you aren't under a doctor? You
11 aren't working under a doctor in that department?

12 DR. LAINE: In other words, what you are trying
13 to say is that a patient comes in. The doctors say "You do this
14 on the patient's foot", and I carry it out.

15 Is this your reference?

16 DR. BUTT: No, I'm saying you are directly under
17 a physician in that hospital?

18 DR. LAINE: Yes.

19 DR. BUTT: And he is responsible for the work
20 that's carried out in that clinic?

21 DR. LAINE: Yes, I think this is true of all the
22 clinics, is it not?

23 DR. BUTT: Well, I won't debate that.

24 MR. CASWELL: Well, I think Dr. Butt has asked
25 a couple of the questions that I was going to ask.



DR. BUTT: Do you feel that you have an autonomous

ing it to our clinic for treatment.

Is there a physician in that hospital?

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MR. GARDWELL: Well, I think Dr. Butt has asked



1 I take it from what you have said then that
2 the majority of podiatrists have their own office calls, and
3 the majority don't work directly through hospitals?

4 DR. LAINE: No, this is as a matter of fact,
5 the hospital work is purely for indigent patients, and we're
6 not reimbursed for that.

7 MR. CASWELL: Is the majority of your business
8 on referral from a physician, or from patients coming directly
9 to you?

10 DR. LAINE: Patients coming directly. We receive
11 a lot of referrals, but this is nebulous. There are consider-
12 able referrals.

13 MR. CASWELL: In replying to a question of Miss
14 McArthur's, were you suggesting that it would be agreeable to
15 your Association if Bill 163 covered your services in a limited
16 and direct capacity?

17 In other words, it referred to just certain
18 services, or were you suggesting this would be satisfactory to
19 you, if it was satisfactory to the medical profession as well?

20 You mentioned this if the Act stipulated that you
21 were reimbursed for your services, just as you said, that any
22 services should be spelled out in the Act that you are going to
23 do?

24 DR. LAINE: No. Just as the services are scheduled
25 for now.



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MR. GOSWELL: In reply to a question I Miss

McArthur's, were you suggesting that it would be agreeable to

Your Association if Bill 108 covered your services in a limited

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DR. LAINE: No. Just as the services are schedule



1 MR. MULROONEY: Dr. Laine, in your presentation
2 you stated that minor surgical procedures are carried out in your
3 office. Is that correct?

4 DR. LAINE: Yes.

5 MR. MULROONEY: Could you give us some details?
6 I would like to know, for example, whether you are referring
7 to amputation, say, of a toe, or removal of a bone?

8 How extensive is this?

9 DR. LAINE: Well, it's relegated to the minor
10 surgery. Amputation is a thing we avoid, and this is the type
11 of thing we don't go into.

12 Correction of minor lesions of the foot is
13 within our province.

14 MR. MULROONEY: Do you have a fee schedule?

15 DR. LAINE: Yes, we do.

16 MR. MULROONEY: I think that the Enquiry would
17 like to see your fee schedule.

18 DR. LAINE: I don't happen to have one here.

19 THE CHAIRMAN: You can send it to the Secretary.

20 MR. CASWELL: Is the podiatrist qualified to do
21 surgery on the foot, that is amputations?

22 DR. LAINE: No, not amputations.

23 THE CHAIRMAN: Nor licensed?

24 DR. LAINE: No.

25 MR. MAJOR: Sir, you mentioned that you had something



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 2 you stated that minor surgical procedures are carried out in your
 3 office. Is that correct?
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 6 I would like to know, for example, whether you are referring
 7 to amputation, say, of a toe, or removal of a bone?
 8 How extensive is that?
 9 DR. LAINE: Well, it's related to the minor
 10 surgical procedures that are carried out in the
 11 office.
 12 Correction of minor lesions of the foot is
 13 carried out.
 14 MR. MURROONEY: Do you have a fee schedule?
 15 DR. LAINE: Yes, we do.
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 17 like to see your fee schedule.
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 19 THE CHAIRMAN: You can send it to the Secretary.
 20 MR. CASWELL: Is the podiatrist qualified to do
 21 surgery on the foot, that is amputations?
 22 DR. LAINE: No, not amputations.
 23 THE CHAIRMAN: Not ligaments?
 24 MR. CASWELL: Yes.
 25 MR. MAJOR: Sir, you mentioned that you had something



1 there from the Michigan Blue Shield Plan?

2 DR. LAINE: Yes.

3 MR. MAJOR: You don't happen to have the
4 enabling act with you from Michigan?

5 DR. LAINE: No, I'm not sure. I don't think
6 I have.

7 MR. MAJOR: Well, I want for the purposes of
8 this Enquiry to clarify a particular field. In the United
9 States all the Blue Shield plans get their legal authority to
10 operate through what is known as an enabling act.

11 DR. LAINE: Oh, yes.

12 MR. MAJOR: Now, in this enabling act their
13 sphere of influence in some cases, and in some States, has been
14 worded in such a manner that the organization known as the Blue
15 Shield Plan may make agreements with purveyors of health services
16 for the treatment of health conditions.

17 Now, in the Blue Shield plans that you are refer-
18 ring to it would appear to me that the State legislature has
19 passed something that has said that because this enabling act
20 is written in terms of a service, anybody that comes under
21 this enabling act as a purveyor of service must be recognized.
22 Is that right?

23 DR. LAINE: This is true in some of the States.
24 Not in all of them. They have come under this, as a matter of fact
25 they have had to go to court in some of these cases, but in many

there from the Michigan Blue Shield Plans?

DR. LAMME: Yes.

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Is that right?

DR. LAMME: This is true in some of the States.

Not in all of them. They have come under this, as a matter of fact

they have had to go to court in some of these cases, but in many



1 instances an agreement has been come upon without any such thing,
2 without an enabling act, and they are covered, and I think the
3 important point of this whole thing is that in not one of those
4 cases have they had to raise premiums because of the inclusion
5 of podiatry in the service.

6 THE CHAIRMAN: I didn't quite understand your
7 question when you said recognized. Recognized by whom?

8 MR. MAJOR: By the organization, which may be
9 the Blue Shield organization, to recognize these purveyors
10 of health services, regardless of whether they are physicians,
11 or optometrists, or so on.

12 THE CHAIRMAN: Fine. Thank you.

13 MR. MAJOR: However, in may of the States the
14 enabling act reads that this particular organization, known as Blue
15 Shield, is going to cover the services of a physid an, a
16 licensed medical practitioner. Now, in those States has there
17 been any interpretation that included in the word physician
18 should be those persons in the practice of podiatry, or osteopathy,
19 or so on?

20 Have you any examples of that?

21 DR. LAINE: The way they handle that, the Blue
22 Shield physician, under their definition is any doctor of medicine,
23 M.D. or doctor of osteopathy, D.O., who is legally qualified
24 and licensed to practice medicine, and perform surgery at the time
25 and place the service is rendered. For services covered by this



instances an agreement has been made upon without any such thing
without an enabling act, and they are covered, and I think the
important point of this whole thing is that in not one of those
cases have they had to raise questions because of the inclusion
of pediatrics in the service.

THE CHAIRMAN: I didn't quite understand your

question when you said recognized. Recognized by whom?

MR. MAJOR: By the organization, which may be

the Blue Shield organization, to recognize these purveyors
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THE CHAIRMAN: Fine. Thank you.

MR. MAJOR: However, in any of the States the

Shield, is going to cover the services of a physician, a
licensed medical practitioner. Now, in those States has there
been any interpretation that included in the word physician
should be those persons in the practice of pediatrics, or osteopathy,
or so on?

Have you any examples of that?

DR. JAMES: The way they handle that, the Blue



1 Plan, doctors of dental surgery, D.D.S., and doctors of surgical
2 chiropody, D.S.C, when acting within the scope of the licences
3 are deemed to be physicians. No practitioners other than those
4 specified above shall be deemed to be physicians for purposes of
5 this Plan."

6 MR. MAJOR: And that's the approach that you
7 think is reasonable in respect of this Act, this Bill?

8 MR. LAINE: Yes, it is.

9 MR. MAJOR: And what State was that?

10 MR. LAINE: This is the Government-wide Service
11 Benefit plan, by the United States Civil Service Commission.

12 MR. MAJOR: This is a matter of the government
13 setting up a particular arrangement for a situation in the
14 United States to do this, and they made their own definition?
15 No carrier was instigated, or motivated, on their own to obtain ---

16 DR. LAINE: No, the life insurance companies have
17 handled it this way in their own particular plans, and this is
18 approximately the way they worded it. They have slightly differ-
19 ent wording, but it amounts to the same thing.

MR/RPS 20 THE CHAIRMAN: Have any other members of the
21 Enquiry any questions? I think you understand that having heard
22 the presentation from the other group, a good many of our questions
23 have been answered. Is there any further statement that you
24 would wish to make?

25 DR. LAINE: I don't think so. Thank you very much
for the opportunity of presenting this.



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18 approximately the way they worded it. They have slightly differ-
19 ent wording, but it amounts to the same thing.
20 THE CHAIRMAN: Have any other members of the
21 Body any questions? I think you understand that having heard
22 the presentation from the other group, a good many of our questions
23 have been answered. Is there any further statement that you
24 would wish to make?
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for the opportunity of presenting this.



SUBMISSION OF THE CANADIAN HEALTH INSURANCE

ASSOCIATION

Appearances: G.R. Berry G.N. Watson
R.N. Mackintosh A.H. Jeffery, Q.C.
Dr. J.C. Emmett Corbet L. Drewry

THE CHAIRMAN: I assume you have had the opportunity to read the statement of instructions there and in accordance with that would the gentleman who is to be the spokesman for your group identify himself and introduce your associates and then proceed with your presentation?

MR. BERRY: Thank you Mr. Chairman. My name is George Berry and I am president of the Canadian Health Insurance Association. The gentleman on my extreme right is Dr. James Emmett who is one of the co-chairmen of our Committee on medical service insurance. The gentleman next to him is Mr. Ralph Mackintosh who is vice-president of our Association. On my left is Mr. George Watson, who is co-chairman of our Committee on medical service insurance. Then next to him on the left Mr. Corbet Drewry who is the managing director of our Association, and, finally, Mr. Alan Jeffery who is the chairman of our Legislative Committee.

We have come before you this morning Mr. Chairman believing that Bill 163 implements the principles of a plan of Medical Care Insurance as enunciated by the Ontario Government.

In our submission to your Enquiry, however, we

SUBMISSION OF THE CANADIAN HEALTH INSURANCE

Dr. J.G. Emmett Corbet L. Dwyer

THE CHAIRMAN: I assume you have had the opportunity to read the statement of instructions there and in accordance with that would the gentleman who is to be the spokesman for your group identify himself and introduce your associates and then proceed with your presentation?

MR. BERRY: Thank you Mr. Chairman. My name

is George Berry and I am president of the Canadian Health Insurance Association. The gentleman on my extreme right is

Dr. James Emmett who is one of the chairmen of our

Committee on medical services insurance. The gentleman next

to him is Mr. Ralph Macdonald who is vice-president of our

association. On my left is Mr. George Watson, who is co-chairman

of our Committee on medical services insurance. Then next to

him on the left Mr. Corbet Dwyer who is managing director

of our Association, and, finally, Mr. Alan Jeffery who is

the chairman of our Legislative Committee.

We have come before you this morning Mr. Chairman

believing that Bill 103 implements the principles of a plan

of Medical Care Insurance as envisaged by the Ontario

Government.

In our submission to your Enquiry, however, we



1 have outlined four recommendations for changes which we believe
2 will help to achieve the objectives of the Bill . . . and also
3 have suggested some technical changes designed for the same aim.

4 Because we, too, believe in the principles stated
5 by the government, our over-riding desire is to be helpful in
6 all of our comments . . . which we make from a careful study of
7 the Bill and from our background of experience in medical care
8 insurance, which runs over several decades, and covers many
9 hundred of thousands of Ontario families.

10 Perhaps you will permit me to remind the members
11 of the Enquiry that our experience extends also to a detailed and
12 intimate co-operation in another province with government, the
13 medical profession and the prepaid or service plans in establishing
14 . . . successfully we believe . . . a somewhat similar Plan to
15 that we are now considering.

16 I sincerely hope our submission gives you an
17 accurate picture of our underlying philosophy . . . that improve-
18 ments and extensions in medical care insurance can be achieved
19 through the close, continuous and conscientious co-operation
20 of government, the medical profession and the present carriers
21 of this type of insurance. As business organizations we recognize
22 and accept our responsibility and place in the changing outlook
23 in Canada toward medical care insurance.

24 Perhaps a word about our particular function
25 would not be out of place. Medical care insurance is a method



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 2 have suggested some technical changes designed for the same aim.
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 4 by the government, our over-riding desire is to be helpful in
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1 of FINANCING the costs of medical care required by individuals
2 or families. That is the function of the insurance companies
3 . . . financing the costs through sound insurance principles
4 . . . and throughout our submission we have tried to confine
5 our remarks to this field, with the objectives of the government
6 clearly in mind.

7 We realize, of course, that the continuation of
8 the highest standards of medical care is the prime concern of
9 all and this must in no way be hindered or interfered with by
10 methods of financing.

11 We are here to answer any questions you may
12 care to put to us on Bill 163 and our submission, which fully
13 explains our recommendations and the reasons for them. In
14 discussing the insuring of individuals whose age or health,
15 or occupation presupposes high claims payments, we have offered
16 suggestions as to the level of the maximum premiums mentioned
17 in the Bill. It is recognized that at these premium levels
18 the high-cost risks as a group will in total produce a loss,
19 and we are proposing a "pooling arrangement" to spread any loss
20 over the whole body of policyholders. Such, it appears to us,
21 is sound insurance practice as premiums are directly related to
22 the benefits to be paid and the class of risk to be insured.

23 We have commented upon subsidy arrangements, as
24 we felt that you would be interested in our views; although we
25 quite recognize this is purely a matter for government decision.

of financing the costs of medical care required by individuals or families. That is the function of the insurance companies . . . financing the costs through sound insurance principles . . . and throughout our submission we have tried to confine our remarks to this field, with the objectives of the government

clearly in mind.

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We are here to answer any questions you may care to put to us on Bill 163 and our submission, which fully explains our recommendations and the reasons for them. In discussing the insuring of individuals whose age or health, or occupation presupposes high claims payments, we have offered suggestions as to the level of the maximum premiums mentioned in the Bill. It is recognized that at these premium levels the high-cost risks as a group will in total produce a loss, and we are proposing a "pooling arrangement" to spread any loss over the whole body of policyholders. Such, it appears to us, is sound insurance practice as premiums are directly related to the benefits to be paid and the class of risk to be insured.

We have commented upon auxiliary arrangements, as we felt that you would be interested in our views; although we quite recognize this is purely a matter for government decision.



1 Our recommendations regarding the inclusion of
2 a plan in which part of the total cost of medical care is paid
3 by the policyholder at the time the medical service is rendered
4 . . . instead of the in-hospital plan proposed in the Bill . . .
5 arises from our past experience in administering such contracts.

6 We are now ready for any questions that the Enquiry
7 has.

8
9
10 THE CHAIRMAN: Mr. Berry I congratulate you
11 and your Association for the very thorough manner in which your
12 brief has been prepared and presented here. I believe that
13 your organization and other organizations who have submitted
14 briefs and who have presented delegations here can be of
15 material help to this Enquiry and there will be some questions
16 to ask you by our members. Mrs. Aylen?

17 MRS. AYLEN: Thank you Mr. Chairman. It is
18 quite a responsibility to be the first one to ask questions
19 because I know there are going to be a great number, but I
20 am going to ask you two or three. The first question I have
21 is on page 8 of the summary, you say that schedule A presents
22 a problem in doctor-patient relationship, and then on page
23 14 you elaborate on this, your reasons for this. You say on
24 page 15 there is a tendency where there is in-hospital coverage
25 alone, to delay release of patients to either a nursing home or

Our recommendations regarding the inclusion of a plan in which part of the total cost of medical care is paid by the policyholder at the time the medical service is rendered . . . instead of the in-hospital plan proposed in the Bill . . . arises from our past experience in administering such contracts. We are now ready for any questions that the Industry

THE CHAIRMAN: Mr. Barry, I congratulate you and your Association for the very thorough manner in which your brief has been prepared and presented here. I believe that your organization and other organizations who have submitted briefs and who have presented delegations here can be of material help to this Ministry and there will be some questions to ask you by our members. Mrs. Ayles?

MRS. AYLES: Thank you Mr. Chairman. It is quite a responsibility to be the first one to ask questions because I know there are going to be a great number, but I am going to ask you two or three. The first question I have is on page 8 of the summary, you say that schedule A presents a tendency where there is in-hospital coverage alone, to delay release of patients to either a nursing home or



1 to their own homes. Now, what in your opinion are the benefits
2 that they are receiving in hospital that makes them wish to
3 remain there?

4 MR. BERRY: I think Mrs. Aylen that where a
5 patient has in-hospital coverage only, there are bound to be
6 occasions when the patient, who might go home and then have
7 no further benefits, would ask or try to persuade the physician
8 to extend his stay. I think there is an actual tendency to
9 this, in any event, where you have home problems.

10 I am sure that Dr. Butt and Dr. Hamilton would
11 agree that where you have home problems, such as nobody there
12 to look after the person, this kind of thing means there will
13 always be attempts by the patient to persuade the doctor that
14 if they can only stay until tomorrow night, or until the
15 weekend, or something, things will be better.

16 We think this might be accentuated if, coupled
17 with it, there was the fact that staying in hospital the bills
18 were being paid but if you went home they fall back on the
19 patient.

20 MRS. AYLEN: You think if benefits were extended
21 beyond the hospital, it would release patients?

22 MR. BERRY: Yes, I think that tendency would
23 be diminished. Maybe Dr. Emmett might care to answer that.

24 DR. EMMETT: If you add anything to in-hospital
25 coverage, you are closer approximating other plans which we are

to their own homes. Now, what in your opinion are the benefits that they are receiving in hospital that makes them wish to

MR. BERRY: I think Mrs. Ayles that where a

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I am sure that Dr. Pratt and Dr. Hamilton would

agree that where you have home problems, such as nobody there

to look after the person, this kind of thing means there will

be a great deal of trouble in the home, and that is why

the hospital is a place where they can get the best of

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We think this might be accentuated if, coupled

with it, there was the fact that staying in hospital the bills

were being paid but if you went home they fall back on the

MRS. AYLES: You think if benefits were extended

beyond the hospital, it would release patients?

MR. BERRY: Yes, I think that tendency would

be diminished. Maybe Dr. Emmett might care to answer that.

DR. EMMETT: If you add anything to in-hospital

coverage, you are closer approximating other plans which we are



1 all in favour of. Was the purpose of your question to extend
2 it to nursing homes?

3 MRS. AYLEN: We had many briefs on extended
4 health service, and I would like your opinion on what facets
5 you think would be important.

6 THE CHAIRMAN: The Victorian Order of Nurses
7 brief.

8 MRS. AYLEN: That answers that. We have had
9 several briefs suggesting that psychiatric care should be
10 included. Have you any thoughts on that?

11 MR. BERRY: I think this is getting into the
12 doctor's area. If I might ask Dr. Emmett if he would care
13 to comment on that.

14 THE CHAIRMAN: I think we would like the answer
15 to that -- I might suggest that the answer should be strictly
16 from an insurance standpoint.

17 DR. EMMETT: I think, sir, we do understand that
18 and as indicated in Mr. Berry's opening remarks, or comments
19 in regard to medical care in general, certainly they would
20 apply to psychiatric care and would only involve an insurance
21 principle. I think the insuring of psychiatric care on
22 insurance principles is one of the very great problems that we
23 have run across in attempting to be of assistance to you. We
24 have now, I speak on behalf of C.H.I.A., had several long-term
25 discussions with the Ontario Psychiatric Association in this

1 all in favour of. Was the proposal of your question to extend

2 it to nursing homes?

3 MRS. ALLEN: We had many letters on extended

4 THE CHAIRMAN: The Victorian Order of Nurses

5 MRS. ALLEN: That answers that. We have had

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12 MR. BERRY: I think, sir, we do understand that

13 and as indicated in Mr. Berry's opening remarks, or comments

14 in regard to radical care in general. Certainly they would

15 apply to psychiatric care and would only involve an insurance

16 principle. I think the turning of psychiatric care on

17 insurance principles is one of the very great problems that we

18 have run across in attempting to be of assistance to you. We



1 regard.

2 As a result of these discussions, it is evident
3 that with the evolution of adequate medical care, and those
4 practising in this specialty have been increasingly act-
5 ive an additional burden has been thrown in their direction.
6 It also appears that this burden will increase in the future.

7 The problem of supplying psychiatric service
8 on demand, I think everyone is in agreement that it is most
9 difficult to consider those services that are being asked for
10 on the basis of emotional disturbance, mental illness or in
11 some instances, from a straight problem standpoint and it is
12 our thought that these, if used exhaustively and extensively,
13 could not help but result in a great increase in the cost of
14 the premium to the public, regardless of the method that is
15 used.

16 In consultation with them, I think that we
17 are in agreement there should be some financial control. I
18 think we would require further discussions to actually spell
19 out what the form of that financial control should take. There
20 are many methods in which this could be considered. The
21 decision that has been reached in the Province of Alberta,
22 following similar discussions, is that it involves a waiting
23 period of a year subsequent to the policy being issued, and
24 then subsequent to that a limitation of a visit per month for
25 psychotherapy. Does that answer your question?



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then subsequent to that a limitation of a visit per month for



1 MRS. AYLEN: As you probably are aware, we
2 are not, all of us, as familiar with all the expressions used
3 in the insurance world, and I wonder if you could explain
4 the difference between a non-profit carrier and those represented
5 by your Association?

6 MR. BERRY: I think we would like to try to
7 answer that question Mrs. Aylen. I think the term "non-profit"
8 has become regarded as exclusive to a certain type of carrier.
9 Personally I think the terms "prepaid", "doctor-sponsored",
10 is a better way of putting it.

11 In our own business, for example, of mutual
12 insurers, providing insurance at cost to their policyholders,
13 they have no stockholders who receive dividends. This in no
14 way should be regarded as critical of stock companies, because
15 stock companies are another approach to this problem of
16 insuring health care, and a basic principle that we submit
17 to the Enquiry is that this job is going to be best done by
18 a multiplicity of carriers, developing a multiplicity of
19 plans.

20 One of the very important benefits that there
21 is in this multiple approach is that where you have a stock
22 company, and believe me the stock companies would be glad to
23 tell you that their experience in the health insurance field
24 has produced nothing very much in the way of dividends --
25 this competition, that is the spur of the need to make profit,

MRS. AYLEN: As you probably are aware, we are not, all of us, as familiar with all the expressions used in the insurance world, and I wonder if you could explain the difference between a non-profit carrier and those represented by your Association?

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1 is a very important factor in seeing that people, all people
2 in the field run their business effectively. I don't think
3 there is any virtue, any particular virtue in the term "non-
4 profit". I think all of these organizations have a place and
5 that the more of them we have working together to try to
6 improve the mechanics of financing health care, the better I
7 think it will be for the people of Ontario.

8 THE CHAIRMAN: Dr. Galloway?

9 DR. GALLOWAY: Thank you very much Mr. Chairman.

10 MR. CASWELL: Mr. Chairman, with your permission,
11 I would just like to make a comment which I do not make very
12 often in this direction. I am most interested in the comment
13 Mr. Berry has just made, and I certainly hope that the press
14 heard his words because there has been considerable comment
15 in the press about the fact that this Enquiry seemed to be
16 interested in directing this coverage to individual carriers
17 at the cost of the people of the Province of Ontario. In
18 other words, intimating that the cost would be considerably
19 higher than if this were handled by the Province. It is most
20 interesting to hear Mr. Berry say that competition is extending
21 benefits to the people in Ontario by giving them the lowest
22 possible rates.

23 DR. GALLOWAY: Mr. Berry, in the opening remarks
24 that you made on your brief you said that, No. 3, the insurance
25 industry recognizes that only doctors can provide medical care



in a very important factor in seeing that people, all people
in the field run their business effectively. I don't think
I have to say more, and I am sure that the people of Ontario
will be for the people of Ontario.

MR. GALLAGHER: Thank you very much Mr. Chairman.

I would just like to say a word when I do not make very
often in this direction. I am most interested in the comment
Mr. Barry has just made, and I certainly hope that the press
will give it the same attention that it has given to the
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benefits to the people of Ontario by giving them the lowest

DR. GALLAGHER: Mr. Barry, in the opening remarks
that you made on your first year when, No. 3, the insurance
industry recognizes that only doctors can provide medical care



1 and that the role of insurance companies is only to help devise
2 the means of financing the cost of such care.

3 THE CHAIRMAN: Dr. Galloway, I am sorry, I did
4 not hear your quote.

5 DR. GALLOWAY: It is page 3 in paragraph numbered
6 9 and it is not really important that you read it.

7 THE CHAIRMAN: Thank you.

8 DR. GALLOWAY: Because the question I have has
9 to bear on the estimation of what you say that the maximum
10 rates would be, and I wondered if you had interpreted this
11 Act, as so many people have that medical services, as it
12 states, are truly medical and not health services. We have
13 had submissions, for example, from many different organizations,
14 ones who were here before, the podiatrists, the osteopaths,
15 the chiropractors, who wish to have this interpreted as health
16 service. In making up your maximum subscription rate how
17 did you interpret this wording?

18 MR. BERRY: Mr. Watson, who is an actuary,
19 I think might answer this question.

20 MR. WATKINS: Dr. Galloway we made our estimation
21 based upon the Bill as it was written, on the assumption that
22 we were talking about medical care as it is normally considered.
23 We hadn't taken into account all the various extensions that
24 might flow from it.

25 DR. GALLOWAY: Thank you. In making up your



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we were talking about medical care as it is normally considered.

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might flow from it.

DR. GALLAGHER: Thank you. In making up your



1 maximum subscription rate would you indicate briefly, and
2 I realize to you this is likely a very simple thing to
3 make up a maximum subscription rate, what are the principles
4 that you used to establish what this would be? How do you
5 go about it?

6 MR. WATSON: Dr. Galloway that question
7 intimately is connected with the setup of the pooling arrange-
8 ments. The two are interlocked, because what we have to do
9 is to try to determine the maximum premium which will be
10 within the competence of people to pay, and yet will not
11 throw too much of a loss on to the body of policyholders,
12 because if that happened, of course, it would be impossible
13 to carry on business of medical care insurance so that the
14 way we attacked it was to find what is the current cost for
15 the aged in the province, those over age 65.

16 We had certain experience available to us in
17 that regard and we tried to equate that experience as closely
18 as we could to the kind of benefits that are envisaged in
19 the Act. I think for the necessary adjustment for operating
20 expenses, and the cost of operating M.C.I., we developed for
21 a single person a rate of approximately \$7.40 per month, for
22 a single male and then by making a deduction from that, to
23 allow for a taxing back on to our individual policyholders,
24 we developed a lower premium of \$6.25, which is the figure
25 that obtained in the brief, and then that figure of \$6.25 is,

maximum subscription rate would you indicate briefly, and I realize to you this is likely a very simple thing to make up a maximum subscription rate, what are the principles that you need to establish what this would be? How do you go about it?

MR. WATSON: In answer to that question intimately is connected with the nature of the pooling arrangement. The two are intertwined, because what we have to do is to try to determine the maximum premium which will be within the competence of people to pay, and yet will not throw too much of a load on to the body of policyholders, because if that happened, of course, it would be impossible to carry on business of medical care insurance so that the way we attacked it was to find what is the current cost for the aged in the province, then over age 65.

We had certain expenses available to us in that regard and we tried to relate that experience as closely as we could to the kind of benefits that are envisaged in the Act. I think for the necessary adjustment for operating expenses, and the cost of operating M.C.I., we developed for a single person a rate of approximately \$7.50 per month, for a single male and then by making a deduction from that, to allow for a saving back on to our individual policyholders, we developed a lower premium of \$6.25, which is the figure that obtained in the brief, and then that figure of \$6.25 is



1 therefore, intended to produce a loss with respect to anyone
2 who may purchase medical care insurance over the age of 65.
3 That loss sir, of course, according to the pooling arrangement
4 that we envisage will be taxed back, or assessed back against
5 our policyholders and will produce a cost on all persons with
6 medical care insurance in the Province we estimate of
7 something in the order of 10¢ monthly. It may be lower than
8 that. We hope and trust it will be but it will be something
9 of that magnitude.

10 *... saying ...* MR. NAYLOR: Would you clarify that 10¢ a
11 month? Per what?

12 MR. WATSON: 10¢ a month per person insured
13 for medical care insurance in the Province regardless of whether
14 they are insured under group insurance or under individual
15 policies and regardless of whether this was a prepaid plan of
16 an insurance company and regardless whether they were insured
17 under their own arrangement or whatever it was. In other words,
18 it was an attempt to assess it back against all persons
19 insured in the Province, per adult life.

20 MR. BERRY: Might I add one small comment to that
21 Dr. Galloway? I am sure the Enquiry appreciates that the
22 premium set out in the brief is a maximum premium beyond which
23 no carrier will go, and it would be anticipated that in a
24 large proportion of cases the insurance could be sold at a lower
25 rate and carriers would compete. I think this is very important



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rate and carriers would compete. I think this is very important



1 to the whole idea that there would still be competition among
2 carriers, in order to endeavour to keep premiums in the
3 population as a whole as low as possible.

4 DR. GALLOWAY: I did appreciate that. Thank
5 you. We had several briefs that had recommended to us in the
6 prepaid plans they have been doing their own pooling, particularly
7 for the people of 65 and over, which is somewhat different
8 than those of the experience rated plans. Would this premium
9 be affected adversely if the prepaid plans and those that are
10 carrying their own proportionate share of 65 and over, be
11 materially altered by the experience rated plans?

12 MR. WATSON: Your question was if the prepaid
13 plans continued to conduct their business as they are now
14 conducting it?

15 DR. GALLOWAY: That is true.

16 MR. WATSON: The pooling arrangement that we
17 contemplated is that anyone who issues a policy at the maximum
18 premium rate would pool the risk. Now an insurance company
19 that elected to offer the same rate for everyone in the
20 community would, of course, offer a rate less than the maximum
21 premium because it would average out, obviously, less than
22 \$6.25, if that is the premium, and, therefore, under those
23 conditions no pooling would occur with a prepaid plan operating
24 on that basis because they have no business issued at the
25 maximum premium, and that is the only kind of business that would



1 come into the pool but, of course, we do contemplate in this
2 rate that there would be an assessment back of all lives insured
3 in the Province and we would hope that assessment would fall
4 on the prepaid plans as well as on the insurance company but
5 if it did not, then I do not believe that it would change this
6 premium. It would simply mean that the recommendation that
7 we have in our brief would apply, and that is that the pooling
8 arrangement would apply to all carriers with a right to
9 apply for exemption and if it appeared to M.C.I. that exemptions
10 on prepaid plans was a desirable thing, and that it would not
11 disturb the whole program, then I think that it might be done
12 without disturbing these maximum premiums.

13 DR. GALLOWAY: I am not quite sure what you
14 mean by "assessment back". Would you explain that to us?

15 MR. WATSON: The pooling arrangement contemplates
16 that there will be a loss with respect to the business that
17 is pooled. As I have explained, the maximum premium is
18 determined in order to produce that result, so when there is
19 a loss generated at the end of one year, that money has to be
20 raised by assessment against the members of the pooling arrange-
21 ment. That is to say against the members of M.C.I. who are
22 not specifically exempt, as we recommend, and in these conditions,
23 therefore, they would be assessed with a pro-rated share of
24 the loss of operation, probably in proportion to the number of
25 adult lives that have been insured for medical care insurance in



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14 DR. CALLOWAY: I am not quite sure what you
15 mean by "assessment back". Would you explain that to us?
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19 is pooled. As I have explained, the premium premium is
20 determined in order to produce that result, so when there is
21 a loss generated at the end of one year, that money has to be
22 pooled in order to produce that result. It is a pooling arrangement.
23
24
25
26
27



1 the Province, regardless of whether it is a standard plan
2 or whether it is a plan under any exception or group or
3 individual, but involving medical care insurance within the
4 definition of the Act.

5 THE CHAIRMAN: Do you mind Dr. Galloway if
6 Mr. Naylor asks a question on this same point?

7 DR. GALLOWAY: No.

8 MR. NAYLOR: Mr. Watson, if there is a carrier
9 using a community rated system carrying their own risk over
10 age 65, and if they were carrying a proportion -- if the
11 number of over-age lives they were carrying was considered
12 to be their fair share, would they likely be assessed with
13 pooling cost, nevertheless? In effect, they might say they
14 are doing their own pooling. Would they get any credit for
15 that?

16 MR. WATSON: Of course Mr. Naylor I was respond-
17 ing to a question whereby they would be exempt. Now if we
18 assume exemption from pooling their risk over age 65, if we
19 are going to make a situation where the prepaid plans would
20 be involved in a pooling arrangement for lives over age 65,
21 I would think that there would be a formula in the pooling
22 arrangement which would adjust for the fact that if they had
23 a larger proportion of the aged, then the remainder of the
24 carriers, that they would get due credit for that and it is,
25 in fact, quite possible in certain plans that an actual payment

THE CHAIRMAN: Do you mind Dr. Galloway if

Mr. Naylor asks a question on this same point?

MR. GALLOWAY: No.

MR. NAYLOR: Mr. Watson, if there is a carrier

using a committee rather than carrying their own risk over

age 65, and if they were carrying a proportion -- if the

number of over-age lives they were carrying was considered

to be their late share, would they likely be assessed with

pooling cost, nevertheless? In effect, they might say they

are doing it on own pooling. Would they get any credit for

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MR. WATSON: Of course Mr. Naylor I was respond-

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1 to them would result rather than an assessment.

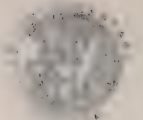
2 THE CHAIRMAN I would like to interject one
3 comment here before turning it back to Dr. Galloway. The
4 way of these questions and discussion is being carried on
5 here, it would be very easy for the press, or others, to get
6 the opinion that we are now determining what the basis would
7 be. I would like to point out to the press that that is not
8 now being done. These are questions that are being asked
9 for information only and for clarification but the way the
10 answers come out, sometimes they appear as though we are
11 deciding on what is being done.

12 MR. BERRY: We are merely talking about
13 principles that might be applied.

14 THE CHAIRMAN: Ideas that you are suggesting,
15 right. Dr. Galloway?

16 DR. GALLOWAY: I have other questions sir but
17 they are not in this trend and I think I would like to turn
18 it over to others who may want to ask questions on this
19 particular area.

20 MR. CASWELL: May I ask one question at the
21 moment? Mr. Berry we are concerned about the fact that this
22 maximum rate could prove to be, shall we say, difficult for
23 the over 65 people, for a lot of them if they were in this
24 maximum rate. Therefore, the maximum rate should be kept as
25 low as possible.



THE CHAIRMAN: I would like to interest one

comment here before turning it back to Dr. Galloway. The way of these questions and discussion is being carried on here, it would be very easy for the press, or others, to get the opinion that we are now determining what the basis would be. I would like to point out to the press that that is not now being done. These are questions that are being asked for information only and for clarification but the way the answers come out, sometimes they appear as though we are deciding on what is being done.

MR. HENRY: We are merely talking about

principles that might be applied.

THE CHAIRMAN: Does that you are suggesting,

right, Dr. Galloway?

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MR. CAMPBELL: May I ask one question at the

moment? Mr. Henry we are concerned about the fact that this maximum rate could prove to be, shall we say, difficult for the over 65 people, for a lot of them if they were in this maximum rate. Therefore, the maximum rate should be kept as low as possible.



1 MR. BERRY: That is right.

2 MR. CASWELL: It suggests to me, from what
3 you have said, that through the pooling or taxing back, as
4 you have suggested, you have estimated approximately \$1.15,
5 from what you figured out in statistics. Your rate was \$7.40,
6 take off \$1.15 brings it to \$6.25 and this would average out
7 to 10¢ per adult person insured so this suggests to me if
8 the good risks rate was a little higher so that it could be
9 20¢, then you could lower the maximum rate to \$5 couldn't you?

10 MR. BERRY: Theoretically, yes, I think this
11 is true. You could progress until you came to the point of
12 a community-rated plan where everybody pays the same amount,
13 regardless of age. Again, these are two different philosophies
14 sir and I point out, and I am sure Mr. Major would agree, that
15 the prepaid plans and the carriers have competed for the
16 insuring of the people of Ontario and we wound up where we
17 both have about half and half so that it seems pretty obvious
18 there are virtues in each system, unless you decide to shift
19 over to one system which as I have said we do not think is
20 to the benefit of the people of Ontario, you are going to
21 have more than one system working side by side and it becomes
22 a matter of working out -- the figures we put in the brief,
23 as the Chairman pointed out, are an example. We don't think
24 that you can afford to step the top down too far or you will
25 interfere with the business of insuring everybody else. I think

MR. GIBNEY: That is right.

MR. GIBNEY: It suggests to me, from what

you have said, that through the pooling or taxing back, as

you have suggested, you have estimated approximately \$1.15,

from what you figured out in another place. Your rate was \$7.40,

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as the Chairman pointed out, are an example. We don't think

that you can afford to stay the top down too far or you will

interfere with the business of insuring everybody else. I think



1 in the case of the aged sir there are two or three things which
2 might well be kept in mind and which, I am sure, the Committee
3 is conscious of. No. 1: There is a growing tendency by the
4 over-age 65 people to continue to be insured under both
5 prepaid plans; have been doing this for some time but there
6 is a growing tendency among groups carried by insurance carriers,
7 that retired people stay on the program.

8 In the second place, if the subsidy arrangement,
9 which the plan contemplates, actually came into being, then
10 a very large proportion of the over 65 would qualify, anybody
11 who is in the low income group would get assistance. This
12 again would bring the cost down. We think this premium should
13 be within the competence, as Mr. Watson said, of most people --
14 I was going to say everybody but you can never make that
15 kind of a statement, but certainly the vast majority of the
16 elderly we think would be eligible.

17 MR. CASWELL: We are still groping in the dark
18 a bit for an answer. It seems the good risks should be ready
19 to pay. What you have said about if it is possible to subsidize
20 a certain income level, then this would help a lot for the
21 over 65. Thank you very much.

22 MR. NAYLOR: In your brief, you have a section
23 explaining pooling arrangements and the need for it, and
24 in answer to some of the questions you have given some
25 additional explanation of that. This is quite a technical



1 in the case of the aged and there are two or three things which
2 might well be kept in mind and which, I am sure, the Committee
3 is conscious of. No. 1: There is a growing tendency by the
4 over-age 65 people to continue to be insured under both
5 prepaid plans; have been doing this for some time but there
6 is a growing tendency to continue to be insured under both
7 that retired people stay on the program.
8 In the second place, all the subsidy arrangement
9 which the plan has suggested, actually come into being, then
10 a very large proportion of the over 65 would qualify, anybody
11 who is in the low income group would get assistance. This
12 again would bring the cost down. We think this premium should
13 be within the resources of Mr. Watson said, of most people --
14 I was going to say everybody but you can never make that
15 kind of a statement, and I am sure that Mr. Watson is
16 elderly we would want to be eligible.
17 Mr. WATSON: We are still working in the dark
18 a bit for an answer. It seems to me that risks should be ready
19 to pay. What we have also said is it is possible to subsidize
20 a certain income level. When this would help a lot for the
21 over 65. Thank you very much.
22 Mr. WATSON: In your brief, you have a section
23 explaining possible arrangements and the need for it, and
24 in answer to some of the questions you have given some
25 additional explanation of that. This is quite a technical



1 matter and I just wondered if you would like to add any
2 further explanation in as simple manner as possible, in
3 layman's language about the pooling arrangements. I think
4 this might be helpful to the members of the Enquiry.

5 MR. BERRY: If I might make one very brief
6 comment. I would like to ask Mr. Watson, who is the expert
7 in these matters to answer. It is fundamental to the concept
8 which the Government is putting forward that coverage should
9 be made available to every person in Ontario. Now this
10 by itself is by no means sufficient. Unless you have some
11 system under which you go out and present this offer to people,
12 they will not, in many cases, come forward of their own accord
13 and subscribe to it. What you want is an arrangement which
14 permits, which encourages, every carrier, no matter who it is,
15 to go out and do their best to persuade these people to come
16 in and be insured and the arrangement must not permit any
17 carrier to sit back and do nothing and, thereby, make its
18 business lower cost than its competitor who has gone out and
19 worked harder to carry out the government's desire. So that
20 this is one of the purposes of the pooling arrangement,
21 in order that company X, for example, or maybe because
22 of the way it is organized it is not able to go out and
23 solicit as many of these people they do not, thereby, benefit
24 as against company Y who because of this organization has
25 been able to go out and insure a large number.



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1 ... Having said that, George, would you like to
2 add anything?

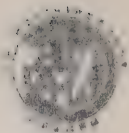
3 MR. WATSON: Our President has said almost all
4 there is to say; however, I will make one additional comment.

5 The pooling arrangement is an absolute necessity
6 as far as our carriers are concerned because we are not solely
7 in the business of medical care insurance and our representatives
8 in the field have a variety of policies which they will sell.

9 If this plan is to be successful, in the
10 eyes of the government and the people, we must end up with a
11 considerable proportion of the population insured and to do
12 that we need to put forth the maximum effort.

13 Now, it is very important, therefore, that any
14 particular carrier makes sure that its individual salesmen will
15 vigorously promote this plan and vigorously approach the aged
16 and the infirm and all types of people who are not covered.

17 Normally an insurance company does not go out
18 and seek the aged and the infirm and it is second nature to
19 them to look in other directions for business that will prove
20 to be healthy business for their company. So it is that the
21 pooling arrangement is designed so that they will act in a
22 community spirit and, yet, not to the detriment of their
23 company and it is only in this way that we can guarantee that
24 all our members will act vigorously and knowing that whatever
25 they do, the losses generated will be assessed back against all



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all our members will get vigorously approaching that whatever

they do, the losses generated will be assessed back against all



1 the carriers and that the only result will be that they will
2 get that assessment, whether they develop the business or
3 whether somebody else develops it.

4 So this is essential if we are to have a final
5 and successful program.

6 It is the easiest thing in the world to develop
7 a program like this and make this available in theory, but
8 in fact not actively promote it, and if that happens the
9 results would be indifferent.

10 THE CHAIRMAN: I assume that in this pooling
11 arrangement the charge-back, or tax to all companies does not
12 provide a profit? This is the charge-back only to prevent
13 loss; is that right?

14 MR. BERRY: That is right. This is merely to
15 separate the losses, having taken risks on a premium that
16 proves to be inadequate for the claims that come in.

17 THE CHAIRMAN: The motivating factor to which
18 Mr. Watson was referring in going after this business is the
19 commission paid to the salesmen?

20 MR. WATSON: We are asking our people to vigorously
21 participate in a community effort for the good of the community
22 and at least they know that their company is not going to
23 suffer by their activities.

24 MR. MAJOR: I think you must realize, Mr.
25 Chairman, that minimizing losses in a general insurance business



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Chairman, that minimizing losses in a general insurance business



1 is augmenting profits. It has an effect on profits -- there
2 is no doubt about that.

3 MR. BERRY: I do not follow that comment, Mr.
4 Chairman.

5 THE CHAIRMAN: I think we are getting into a
6 debating situation, which is not the intention of this
7 Enquiry.

8 MR. WHITNEY: Mr. Chairman, are we going on
9 with pooling? May I ask a question?

10 THE CHAIRMAN: Yes.

11 MR. WHITNEY: Probably Mr. Watson can answer
12 this. On page 10, you mention in paragraph 23 that under the
13 pooling you consider that opting out of the pooling arrangement
14 for the under 65's might be permitted, but not the over 65
15 group. It is necessary to make a distinction considering,
16 generally, who might be exempt from pooling -- make a distinction
17 on the basis of under 65 and over 65? Would you like to
18 amplify that?

19 MR. WATSON: Mr. Whitney, we felt that it was
20 desirable to have all carriers in the pool and the recommendation
21 in regard to having two pools, one under 65 and one over 65,
22 is that the over 65 pool can be readily participated in by
23 prepaid plans because only age is the distinction there; whereas
24 the under 65 pool there applies only in cases of those who
25 are sick or bad risks in some way and prepaid plans do not conduct

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19 prepaid plans because only age is the distinction there; whereas

20 the under 65 pool there applies only in cases of those who

21 are sick or had risks in some way and prepaid plans do not conduct



1 their business in such a way that they can identify those
2 people.

3 We wanted to see the widest possible base for
4 pooling and, therefore, we recommended that they participate
5 and that all carriers participate in the over 65 pool because
6 this gives us a wide base for assessing back the losses. But,
7 in addition, we feel that when we give credit for the
8 high percentage of the aged that some of the prepaid plans
9 have been able to enroll already, that in fact it might be
10 to their advantage to so engage in the pool. Whether it will
11 work out that way or not, it is very difficult to determine.
12 But we felt that it was something that they should look upon
13 with favour because they are currently insuring the aged
14 at figures quite a lot lower than the maximum premium contemplated
15 here and if this maximum premium is correct on the assumptions
16 made they are already incurring a loss and perhaps participation
17 in the pool might be a good thing for that particular group.

18 MR. WHITNEY: On the under 65 group if anyone
19 under 65 asks for a standard contract, are you going to be
20 able to determine whether that risk is a selection against
21 you? Are you going to have a medical statement?

22 MR. WATSON: A personal statement of health,
23 and if that personal statement of health put the individual
24 in a satisfactory risk classification, we would quote a rate
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3 fifty, or something of that order, for a single person -- or
4 even less -- depending upon the age at issue; but if that
5 person couldn't qualify on the basis of his present state
6 of health, the maximum premium might possibly be charged in
7 that event.

8 MR. WHITNEY: Do you think the Act, as it
9 presently stands, permits anyone to ask for a statement of
10 health if the person asks for a standard contract Schedule
11 A?

12 MR. WATSON: We assume that . . .

13 MR. WHITNEY: Is there anything in the Act that
14 supports this?

15 MR. WATSON: The Act, as we read it, provides
16 that a policy must always be made available and the only
17 prohibition is that you must not charge more than the maximum
18 premium. But we feel that there is no prohibition against
2 19 attempting to charge the lowest possible premium and that is
20 the only reason for asking for a personal statement of health.
21 MR. BERRY: Might I add one thing. You appreciate
22 that in the group field where a very large part of this
23 business is done, of course, once you get into a group of any
24 size, a minimum number, which varies somewhat from one carrier
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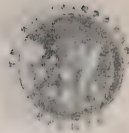
1 question of determining the status of an individual risk.

2 MR. WHITNEY: Yes. I appreciate that. But
3 I am not sure that I agree completely that you can find your-
4 self in a position of being able to take a medical statement
5 on the standard contracts. I am not too sure that the Act,
6 or the concept of the Act, allows this type of thing.

7 MR. WATSON: The principal purpose of taking
8 the personal statement from the insurers, perhaps, is the
9 reverse of what it often is. In this case it is to determine
10 that you do not have to charge the maximum premium -- that you
11 can charge something less. I think I can illustrate the
12 position by the premium situation in Alberta, where the maximum
13 premium is \$5.25 for a single individual. Well, actually the
14 premium rates in Alberta that are being charged to different
15 people range from \$2.75 to \$5.25 and the statement is taken,
16 sir, for the purpose of determining whether you can give the
17 person coverage at \$2.75 or whether you have to charge them
18 a somewhat higher figure, or the maximum.

19 MR. WHITNEY: I can see your point all right.
20 I have one other question, Mr. Chairman.

21 We have had quite a bit of representation on
22 the question of opting out of a number of carriers that have
23 been before us but have been taking their insurance on the
24 basis of no medical statement and taking the over-aged as well.
25 They have been carrying them through. I do not know that their



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1 contracts -- I haven't seen them -- are necessarily specific
2 as to being non-cancellable; so that if an insured does become
3 a poor risk while being carried, he is renewed at the same
4 premium and not at a higher premium.

5 But on this question of opting out, what would
6 you think -- and we are only searching for solutions here,
7 we have no conclusions yet -- what would you think if we
8 allowed those carriers who are now in business and are now
9 carrying the type of risks that we contemplate necessary --
10 to make the pooling arrangement necessary -- say if we allowed
11 consideration to some sort of a board, representations to a
12 board to see whether they qualified for opting out, firstly
13 if they are in business, say, at the time this Bill was first
14 read, so that no one could rush in now and say that they have
15 a proper selection of a poor risk and should be allowed to
16 opt out and, secondly, that they make the contracts non-
17 cancellable and continue to do what they are doing at the present
18 time and providing they can establish that they have a fair
19 selection or a reasonably close selection of this type of
20 poor risk?

21 MR. BERRY: That is quite a long question. I
22 am not quite sure that I have all the pieces straight. Would
23 you mind repeating the last sentence?

24 MR. WHITNEY: Not just the last sentence. I
25 will do it all again for you. We are trying to think how we can



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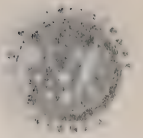
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1 fairly treat the groups who have been before us who are not
2 too, let us say, sure that they want to be in the pooling
3 arrangement. They make a fairly strong case to us on the
4 grounds that there is really no need for them to start in to
5 get into a pooling arrangement of all bad risks when they are
6 at the present time underwriting a fairly good cross-section
7 of poor risks and over-age cases. Now, my thought on it --
8 and it is only a thought and it is a personal thought -- it
9 is not the thought of the Enquiry -- that the solution might
10 be, and we have to find a solution to this -- the solution
11 might be that we permit such carriers to appeal to some board,
12 whether it is an advisory board or an executive committee, to
13 opt out on the grounds (1) that they are in the business of
14 this type of insurance and are taking a good cross-selection
15 of the less preferred risks now and intend to continue to do
16 so and if we told them they had to make their contracts non-
17 cancellable, so that they do not suddenly on renewals start
18 putting the risks out for other carriers to take than in pools.
19 Do you think this might be a good approach to trying to
20 qualify who should be allowed to opt out and who should not be
21 allowed to opt out?

22 **Is that too long for you?**

23 **MR. WATSON:** I think I just want to make a general
24 comment to your general comment, and that is this: That at the
25 present time, carriers in Ontario are offering, in the group



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22 Is that too long for you?

23 MR. WATSON: I think I just want to make a general
24 comment to your general comment, and that is this: That at the
25 present time, carriers in Ontario are offering, in the group



1 side of the business, benefits substantially the same as we
2 see in this Act. The prepaid plans are doing that through
3 the group mechanism; the insurance companies are doing that
4 already. There is nothing new as far as that is concerned.
5 When it comes to the aged, the carriers are offering coverage
6 of this type to the aged if they are in a retired life category,
7 if the employer and the group wishes this coverage.
8 The present carriers are -- the prepaid plans
9 are offering conversion of such coverage when employment is
10 terminated, but there are very few, if any, carriers in Ontario
11 offering an individual policy of medical care insurance like
12 this, or could offer it without some additional protection that
13 we are talking about. They would, perhaps, offer it under
14 group conversion, as many of them are doing now. But to offer
15 it to anyone who walks into their office right off the street,
16 without any prior connection to a group, is largely not being
17 done today. So that any carrier who applied to this board and
18 asked for exemption on that ground, I think this would have to
19 be gone into very carefully because we would say -- we, in
20 our association, would say that the success of this whole
21 program depends upon having every carrier actively soliciting
22 all people, regardless of whether they are in groups or they
23 have just come out of groups, to all people for this individual
24 policy and if they can establish that this was exactly what
25 they were doing today under this broad form of coverage that we



1 are talking about, or are prepared to do it and establish it,
2 I would say they have a very good case for exemption. But I
3 recommend that you put a microscope on that because I doubt
4 that, with the exception of one carrier, that is true.

5 MR. NAYLOR: Just before we leave this point,
6 Mr. Watson, I believe you made a statement in your last remarks
7 to the effect that the prepaid plans are offering conversion
8 privilege to individuals that have been insured in groups, when
9 they leave. Now, is it not true that the insurance companies
10 are doing that equally much? I do not want to leave any
3 11 wrong implication.

12 MR. WATSON: Yes. The insurance companies
13 are offering the conversion policies, although this is not
14 universal. But it is done by many companies. I intended that
15 to be implicit in my remarks and I wish to make that clear.

16 MR. NAYLOR: Mr. Chairman, I have about three
17 other questions.

18 THE CHAIRMAN: There is about three minutes
19 before we recess.

20 MR. NAYLOR: I realize that and these other
21 questions do not relate to pooling. We have been spending
22 a fair amount of time on pooling. Would you like to see if
23 there are any further questions on pooling?

24 DR. BUTT: Following up the statements made,
25 an individual policy, shall we say, on a high risk individual,





1 is a more expensive policy to process by your group?

2 MR. BERRY: I beg your pardon?

3 DR. BUTT: A group taking on an individual,
4 as compared with the individual policy?

5 MR. BERRY: Yes. It costs more money for a
6 single life all by himself -- John Jones, who lives as an
7 individual, is self-employed, no connection, and he comes
8 in. It is more expensive to issue a single policy than it
9 is to handle a mass coverage, for example, for a group of a
10 firm like Canadian General Electric.

11 DR. BUTT: This is basically the group or the
12 individual that you wish to put into the pool? This is where
13 the pool is most effective; isn't that correct?

14 MR. WATSON: Not necessarily. It would depend
15 upon whether he was in the age group or the high cost risk.
16 If he was currently in hospital . . .

17 DR. BUTT: But this is the one you want to
18 get sold?

19 MR. WATSON: This is the problem area.

20 MR. BERRY: And the group might have no reason
21 at all to pool any risk. They might decide that they can be
22 sort of a closed entity and handle all their own lives.

23 MR. SIMON: For a while I thought you were
24 in the business of selling health insurance, medical insurance
25 only. Then Mr. Watson told us here that you are not solely

... process by your group?

MR. BERRY: I beg your pardon?

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is to handle a mass coverage, for example, for a group of a

MR. BERRY: That is basically the group or the

individual that you wish to put into the pool? This is where

the pool is most effective, isn't that correct?

MR. WATSON: Not necessarily. It would depend

upon whether he was in his own group or the high cost risk.

If he was currently in hospital, . . .

MR. BERRY: But this is the one you want to

get out of

MR. WATSON: This is the problem area.

MR. BERRY: And the group might have no reason

at all to pool any risk. They might decide that they can be

sort of a closed entity and handle all their own lives.

MR. SIMON: For a while I thought you were

in the business of selling health insurance, medical insurance

only. Then Mr. Watson told us here that you are not solely



1 in this business, you are also selling something else to the
2 public. You are selling life insurance, I presume, pensions --
3 you are selling indemnity, sickness indemnity, and so on. And
4 I presume you must be making money in the other line of business.
5 So you are selling apples and bananas and you are probably
6 making good money on the apples and losing a little money on
7 the bananas and you want somebody to share the loss on the
8 bananas with you. Isn't that the conclusion that the public
9 has to come to when you suggest this proposal here of pooling
10 on the bad risks?

11 MR. WATSON: There is a simple answer to that,
12 sir, with all respect -- no. We are saying that in the business
13 of medical care insurance there are perfectly valid ways to
14 do business in medical care insurance and still survive
15 financially; otherwise, we wouldn't be in the business.

16 What we are talking about now is something that
17 does not exist in Ontario -- in fact, until it was developed
18 in Alberta it existed nowhere in the world -- and that was
19 taking a risk regardless of its fundamental insurable character-
20 istics. If we were to do that then, obviously, you would
21 attract immediately risks which were beyond the insurance
22 principle entirely and if you were to do that you would have
23 to have some protection, as I have said. If you were to do
24 that, you would have to set up a pool so that the losses are
25 there and are assessed back against the members.



1 Now, having done all that, you may still end
2 up with the members losing money but at least it is a practical
3 means of solving a problem which is not a normal insurance
4 problem because any normal insurance company selects its
5 risks and decide who it will insure and who it will not insure.
6 If you are going to throw away that selection device, you must
7 substitute in its place something and the pooling arrangement
8 is substituted for that. It has nothing to do whatever with
9 the condition or the profit or the lack of profit that may be
10 made at the current time.

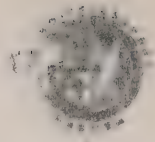
11 MR. SIMON: You said that you reserved the
12 right to charge higher premiums for the risk individuals. So,
13 you want both. You want to reserve the right to charge more
14 money and, at the same time, reserve the right to share the
15 loss.

16 MR. WATSON: The right to charge a higher prem-
17 ium for those people who are, largely, considered uninsurable,
18 who couldn't obtain this coverage anywhere.

19 MR. NAYLOR: You are still limited by the
20 maximums?

21 MR. WATSON: Subject to the limitation on the
22 maximum premium, of course.

23 THE CHAIRMAN: I think we have reached the
24 recess time. If you wish to pursue this further after, we will
25 reconvene at twenty minutes to twelve and carry through until



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recess time. If you wish to pursue this further after, we will

reconvene at twenty minutes to twelve and carry through until



1 quarter after one.

2

3 ---A short recess.

4

3/rps

5 THE CHAIRMAN: Dr. Galloway, Mr. Naylor has
6 mentioned to me you had a specific question?

7

MR. NAYLOR: Did you have a further question?

8

9 DR. GALLOWAY: I have asked my questions, thank
10 you.

11

THE CHAIRMAN: You carry on, Mr. Naylor.

12

13 MR. NAYLOR: I take it we are finished with
14 pooling. My questions go on. I believe that the plan that
15 we are considering in Ontario is similar in many respects to
16 the one that was brought into operation in Alberta last year
17 and I think, therefore, it might be very helpful to the members
18 of the Enquiry if we heard a little more about the results
19 in Alberta, how successful it has been and how enrollment
20 has been done. I wonder if one of your members would have
21 some information on that.

22

23 MR. BERRY: Yes, Mr. Mackintosh might do this.
24 He has been quite active in the arrangements in Alberta and
25 he would be glad to comment on that.

26

27 THE CHAIRMAN: It is the experience we are more
28 interested in rather than going into a detailed description
29 of the system.



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interested in rather than going into a detailed description

of the system.



1 MR. MACKINTOSH: We assumed that this question
2 of the success and the enrollment in Alberta would be of
3 interest to the Enquiry. I have taken the liberty of preparing
4 a brief written report which I can file with the members of
5 the Enquiry with your permission. Do you wish me to read it?

6 THE CHAIRMAN: I can't tell how long it is.

7 MR. MACKINTOSH: It is really quite brief.

8 MR. WHITNEY: Two and a half pages, double
9 spaced.

10 THE CHAIRMAN: Yes, proceed.

11 MR. MACKINTOSH: "REPORT ON ENROLMENT UNDER
12 ALBERTA MEDICAL PLAN

13 "1. Background

14 "The details of the Alberta Medical Plan
15 "were first announced to the people of Alberta
16 "on June 25th, 1963.

17 "The initial 'open enrolment period'
18 "commenced July 1st whereby all applications
19 "received by September 30th became effective
20 "October 1st, without a further enrolment
21 "waiting period. The 'open enrolment period'
22 "was subsequently extended to October 11th because
23 "of the volume of applications being received
24 "during the last few days of September.

25 "At times other than during 'open enrolment



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"was subsequently extended to October 1st because

"of the volume of applications being received

"during the last few days of September.

"At times other than during 'open enrollment



1 " 'periods' by law coverage is effective
2 "from the first day of the fourth month follow-
3 "ing the date of application.

4 "The knowledge and skills acquired in
5 "Alberta could form a useful basis for other
6 "similar programs.

7 "2. Enrolment - Alberta Medical Plan

8 "Prior to introduction of the Alberta
9 "Medical Plan, an estimated 850,000 persons
10 "or 63% of the population were covered by M.S.I. --"
11 I might interject that M.S.I. is the doctor-
12 sponsored prepaid plan in Alberta.

13 " --- and other carriers for medical
14 "services benefits of various types. In
15 "addition some 60,000 people, representing recipients
16 "of government pensions and assistance allow-
17 "ances, were covered by arrangement between the
18 "Alberta College of Physicians and Surgeons."

19 "While an accurate count of those currently
20 "covered by all insurance companies and M.S.I.
21 "will not be available for some months, it has
22 "recently been estimated that a total of 1,100,000
23 "residents are now protected by a prepayment
24 "arrangement for medical care, including those
25 "in receipt of public welfare benefits, Armed



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1 "Forces and persons under miscellaneous federal
2 "and municipal plans. The figure represents
3 "81% of the population.

4 "It is significant that a total of 705,026
5 "persons were covered by Alberta Medical Plan
6 "alone, or 52.2% of the population, on conclusion
7 "of the open enrolment period and including the
8 "transfer of existing M.S.I. contracts to Alberta
9 "Medical Plan coverage.

10 "3. Enrolment of Persons Eligible for Either
11 "Level of Government Subsidy

12 "At the end of the first "open enrolment period",
13 "a total of 171,468 persons enrolled in the Alberta
14 "Medical Plan under government subsidization of
15 "premiums.

16 "Of all persons covered as of October 1st,
17 "approximately one-quarter are in receipt of
18 "government subsidy of premiums.

19 "During this enrolment period, more than
20 "75% of all new applications from persons who
21 "probably had no prior coverage were from persons
22 "eligible for government subsidy.

23 "Prior to implementation of the Alberta
24 "Medical Plan, it was estimated that a total of
25 "450,000 persons were eligible for government



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"Prior to implementation of the Alberta

"Medical Plan, it was estimated that a total of

"450,000 persons were eligible for government



1 "subsidy, either as a single person or a member
2 "of a qualifying family. But it must be
3 "noted that within this total there exist certain
4 "blocks of persons who are not apt to apply for
5 "the subsidy. Such persons include
6 "(a) many thousands of Indians in the
7 "province who are already eligible for med-
8 "ical benefits under federal legislation.
9 "(b) a significant number of persons with
10 "incomes low enough to qualify for subsidy
11 "but who are already protected by adequate
12 "group insurance plans partly or wholly paid
13 "for by employers,
14 "(c) certain religious orders and social groups
15 "holding wealth and property communally.
16 "All of these groups were included in the
17 estimate of 450,000 subsidy-eligible people."

18 "4. General Comments

19 "All figures quoted in this report
20 "refer only to enrolment for coverage effective
21 "October 1st, 1963. Enrolment is still
22 "continuing, subject to the waiting period described
23 "earlier, and while an estimate of the
24 "number of applications being received by all
25 "carriers is not available, M.S.I. alone estimates



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"agencies is not available, M.S.I. alone estimates



1 "it is receiving about 1,000 applications each
2 "month. It is likely that a high percentage
3 "of these are from persons eligible for subsidy.

4 "Immediately it was introduced, the Alberta
5 "Medical Plan achieved the objective of making
6 "broad protection universally available. Enrol-
7 "ment for coverage effective October 1st must be
8 "regarded as only the beginning of the
9 "public's response.

10 "On December 27th, 1963, the Hon. J. Donovan
11 "Ross, Alberta Minister of Health said:

12 "'On the basis of the government's
13 "'experience with the Plan, we expect enrol-
14 "'ment to continue to increase until virtually
15 "'everyone in the province who wants to prepay
16 "'their medical care costs will be covered.'
17 "'Moreover,' he added, 'this coverage has been
18 "'achieved with no disruption in the high
19 "'standard of medical care to which the people
20 "'of Alberta are accustomed.'"

21 MR. NAYLOR: In your brief you have made certain
22 suggestions as to how residents in the lower income classes
23 could be assisted to buy medical insurance. There is one
24 problem that has been raised by some members of the delegations
25 we have heard, that it would be taken care of entirely by the

"it is receiving about 1,000 applications each month. It is likely that a high percentage of these are from persons eligible for subsidy. Immediately it was introduced, the Alberta Medical Plan achieved the objective of making broad protection universally available. Enrollment for coverage effective October 1st must be regarded as only the beginning of the

"On the basis of the government's experience with the Plan, we expect enrollment to continue to increase until virtually everyone in the province who wants to pay their medical care costs will be covered. Moreover, he added, this coverage has been achieved with no diminution in the high standard of medical care to which the people of Alberta are accustomed."

MR. MAYOR: In your report you have made certain

suggestions as to how residents in the lower income classes could be assisted to pay medical insurance. There is one

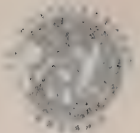


1 subsidy and that a person who is normally in an income class
2 where he wouldn't be entitled to the subsidy has a period
3 of temporary inability to pay through disability or unemployment
4 or lay-off. Have you any suggestions as to how this problem
5 could be solved?

6 MR. BERRY: I think in the first place in the
7 group field there is a fairly general application of lay-off
8 periods which take care of a great many of these cases. Element-
9 ary to the plan of course, is the contract contemplates a
10 31-day grace period which again takes care of short periods
11 of unemployment. When you come to long periods of unemployment
12 it is possible, for example, that something might be done
13 in connection with the Unemployment Insurance Act if that was
14 considered advisable. There are also the facilities available
15 at the municipal level for cases that become real hardship,
16 and it is possible, as is the case in Alberta to have some
17 form of benefit to take care of periods of disability, at
18 least, within some limits. I think there are a number of
19 ways that this could be handled.

20 MR. NAYLOR: Thank you. We have had one or
21 two suggestions to how the administrative expenses of Medical
22 Carriers Incorporated might be allocated to the member carriers.
23 Have you any suggestions or recommendations on that particular
24 point?

25 MR. BERRY: Well, this is one of the things,



subsidy and that a person who is normally in an income class

where he wouldn't be entitled to the subsidy has a period

of temporary inability to pay through disability or unemployment

or lay-off. Have you any suggestions as to how this problem

could be solved?

MR. HENRY: I think in the first place in the

group field there is a fairly general application of lay-off

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in connection with the Unemployment Insurance Act if that was

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ways that this could be handled.

MR. HALLOR: Thank you. We have had one or

two suggestions to how the administrative expenses of Medical

Carriers Incorporated might be allocated to the member carriers.

MR. BERRY: Well, this is about the things,



1 the details of which would have to be hammered out when the
2 mechanism came into being. We felt that it should be the
3 same relationship for example to the extent to which a member
4 organization is in the medical care field, that there should
5 be some fair and equitable distribution of whatever these
6 costs are. At the moment we are not wedded to any single
7 scheme. I think this is the kind of thing that has got to
8 be worked out by the administrative body, if and when it comes
9 into being.

10 THE CHAIRMAN: Mr. Simon?

11 MR. SIMON: Thank you very much, Mr. Chairman.

12 On page 1 of your summary and recommendations you speak about
13 96% of the voluntary health insurance provided by insurance
14 companies in Canada. What does that embrace -- health insur-
15 ance, are you talking about the same thing that Bill 163 is
16 about or are you talking about a wider field, and also what is
17 the percentage of coverage in Ontario for this particular
18 field that is envisaged by Bill 163?

19 MR. BERRY: There are two questions as I under-
20 stand it, Mr. Simon. The first one is merely a statement of
21 the fact that our Association represents almost all the carriers
22 who are in the field of writing health insurance in its
23 various forms. This is merely a statement of the extent of the
24 group of carriers who are our members in our Association. The
25 second question, if I understand you correctly, is what is the



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2 mechanism came into being. We felt that it should be the
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7 scheme. I think this is the kind of thing that has got to
8 be worked out by the administrative body, if and when it comes
9 into being.

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MR. SIMON: Thank you very much, Mr. Chairman.
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12 96% of the voluntary health insurance provided by insurance
13 companies in Canada. What does that embrace -- health insur-
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15 about or are you talking about a wider field, and also what is
16 the percentage of coverage in Ontario for this particular
17 field that is envisaged by Bill 103?

MR. BERRY: There are two questions as I understand it, Mr. Simon. The first one is merely a statement of
21 the fact that our Association represents almost all the carriers
22 who are in the field of voluntary health insurance in its
23 various forms. This is merely a statement of the extent of the
24 group of carriers who are our members in our Association. The
25 second question, if I understand you correctly, is what is the



1 proportion of the people of Ontario at the present time that
2 have some form of coverage against medical care.

3 MR. SIMON: Yes.

4 MR. BERRY: If you look on page (11) and in
5 paragraph 7 we make a general statement about the extent of
6 coverage in Canada which has reached the figure of ten
7 million people, and which has grown rapidly in all its branches,
8 prepaid plans, insurance carriers. There has been very rapid
9 growth over the last ten or fifteen years. You have in Ontario
10 72% of the population that are covered under plans of
11 various kinds.

12 DR. GALLOWAY: Might I ask a question for
13 clarification. This is one I was going to ask. I am not quite
14 sure what you mean when you say 96%. Do you mean your
15 Association is made up of 96% of the carriers or you have
16 96% of the coverage?

17 MR. BERRY: 96% of the business carried by
18 insurance carriers is in force with members of this Association.
19 This doesn't, of course, include prepaid plans. We are merely
20 speaking of our own membership and the business which is done
21 by insurance companies.

22 DR. GALLOWAY: Thank you.

23 MR. SIMON: Someone has told us that only 57%
24 of the population in Ontario were covered for medical insurance
25 in some form. When you say in paragraph 6 on the following page,



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MR. SIMON: Yes.

MR. BERRY: If you look on page (11) and in

paragraph 7 we make a general statement about the extent of

coverage in Canada which has reached the figure of ten

million people, and which has grown rapidly in all its branches,

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DR. GALLOWAY: Might I ask a question for

clarification. This is one I was going to ask. I am not quite

sure what you mean when you say 90%. Do you mean your

Association is made up of 90% of the carriers or you have

90% of the coverage?

MR. BERRY: 90% of the business carried by

This doesn't, of course, include prepaid plans. We are mainly

speaking of our own membership and the business which is for

by insurance companies.

MR. SIMON: Someone has told us that only 5%

of the population in Ontario were covered for medical insurance

in some form. When you say in paragraph 6 on the following page



1 page 2, "that it is unrealistic and unnecessary to institute
2 overall, compulsory, government-sponsored plans applicable to
3 the entire population just to care for this relatively limited
4 group." I don't know since when 47% of the population is a
5 limited group.

6 MR. BERRY: With respect that is not what para-
7 graph 6 says. We say that the group which cannot take care
8 of its own needs if it wants to do so is a relatively limited
9 group. We don't say that all these who can are insured. There
10 are many people who could but for some reason have so far
11 decided not to.

12 MR. SIMON: That is a debatable question, of
13 course.

14 THE CHAIRMAN: How would you get the statistics
15 on which you base your answer to that. Where would these
16 statistics be available of the people who are not eligible
17 for insurance or could afford to buy it?

18 MR. BERRY: Again I am not quite sure of the
19 question. How did we get the statistics -- the statistics were
20 our own statistics of the people who are insured. We say it
21 is 72% and we can document that figure if anyone would like
22 us to. How would you determine how many people are actually
23 unable to purchase insurance protection for themselves I think
24 is a very difficult, almost an impossible task. Obviously
25 it isn't a major proportion of the population of Ontario. We



1 I am not sure that I have understood your question.
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1 don't live in that kind of community.

2 MR. MAJOR: Mr. Chairman, I wonder if Mr. Berry
3 and his associates would be kind enough to document those
4 figures for us and break them down into such figures that it
5 would give us some idea of the number of people of the 72% who
6 have purchased what we term comprehensive medical care, limited
7 medical care and maybe very limited medical care. I wonder
8 if it would be possible to do this for us?

9 THE CHAIRMAN: If you could it would be helpful
10 because the figure you are quoting here seems to me, if my
11 recollection is correct, the highest figure of coverage that
12 has been cited before us. I think it is actually higher than
13 the figure used by the Minister of Health on the floor of the
14 House when he introduced the Bill.

15 MR. MAJOR: I think it would be beneficial to
16 make sure these figures show coverage for medical services
17 comparable to the definition of medical services in the Act,
18 in the Bill.

19 THE CHAIRMAN: Do you think you could provide
20 us with these statistics?

21 MR. BERRY: Excuse me, I wanted to get Mr. Major's
22 comment. Would you mind repeating it?

23 MR. MAJOR: I would like to have for this
24 Enquiry a statement of the compilation that would show the
25 72% broken down into three broad categories, what we would term



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recollection is correct, the highest figure of coverage that

has been cited before us. I think it is actually higher than

the figure used by the Minister of Health on the floor of the

House when he introduced the Bill.

MR. MAJOR: I think it would be beneficial to

make sure these figures show coverage for medical services

comparable to the definition of medical services in the Act,

in the Bill.

THE CHAIRMAN: Do you think you could provide

us with these statistics?

MR. BERRY: Excuse me, I wanted to get Mr. Major's

comment. Would you mind repeating it?

MR. MAJOR: I would like to have for this

Exhibit a statement of the compilation that would show the

72% broken down into three broad categories, what we would term



1 comprehensive physician care comparable to Schedule A, limited
2 physician care comparable to Schedule B and physician care less
3 than that, but not including out-of-work benefits, hospitalization
4 or any other type of health and accident insurance that doesn't
5 include physician service. This, I think, Mr. Berry would
6 automatically eliminate all major medical plans.

7 MR. BERRY: We have some figures on that, sir,
8 which could be brought forward.

9 THE CHAIRMAN: It would be very helpful. Mr.
10 Simon?

11 MR. SIMON: Coming to page 8, I believe this
12 question has already been asked, but I would like more clarific-
2 13 ation with regard to the rates structure you are suggesting
14 here.

15 MR. BERRY: On page -- ?

16 MR. SIMON: On page 8.

17 MR. BERRY: That is right.

18 MR. SIMON: Of the summary and recommendations.
19 I am a layman and I can't figure out, for the life of me,
20 how P.S.I. can still insure for \$10.95 for the same coverage
21 and the same group that you are suggesting a maximum of \$16.04
22 for. What justifies the 50% higher rate, even if it is
23 the maximum rate, I realize that and that they are selling
24 it to all groups, including risk groups.

25 MR. BERRY: We would sell a large part of the



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1. The Commission has been asked to consider the possibility of
2. including in the Commission's report a recommendation that the
3. Commission should not be limited to the consideration of the
4. Commission's report on the Commission's report on the Commission's report

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6. automatically eliminate all major medical plans.

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8. which could be brought forward.

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11. MR. SIMON: Coming to page 8, I believe this
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14. MR. BARRY: On page -- ?
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17. MR. SIMON: Of the summary and recommendations.

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21. MR. BARRY: We would sell a large part of the



1 population at lower rates.

2 MR. NAYLOR: They are not selling it to individuals
3 at that rate.

4 MR. BERRY: This is the basic difference, sir,
5 between the community rating philosophy which applies the
6 same rate to everybody as opposed to the kind of rating which
7 insurance does which varies in rate according to the type of
8 risk. This, of course, is the ceiling rate. I would like to
9 again emphasize that. This is the cut-off point beyond which
10 nobody can be charged more.

11 MR. WATSON: I want to make a point very clear
12 because it is very important, and this has relationship to
13 something else that was said earlier, and that is that there
14 is no carrier, and you mention P.S.I. -- I hesitate to use
15 specific carriers but it was you who mentioned P.S.I. It
16 doesn't offer individual coverage at \$10.75.

17 MR. SIMON: \$10.75 is the group rate, slightly
18 higher for others.

19 MR. WATSON: When adding to that the fact this
20 has to be an individual underwriting and not group and you add
21 to that the fact the individual has to be taken at that rate
22 regardless of his age or his condition of health -- you must
23 realize there is no carrier in Ontario right now who would take
24 that risk at any premium if it was an unrestricted risk as
25 of the commencement of coverage. I am talking about a policy

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higher for others.

MR. WATSON: When adding to that the fact that



1 that begins on the date the premium is paid. There is no
2 company in Ontario that would do that on an individual basis.
3 A prudent company would take a rate somewhat higher than they
4 are being charged at group level.

5 MR. SIMON: Somewhat higher is not 50%.

6 MR. MAJOR: Let us clarify a couple of points.

7 MR. BERRY: May I just before Mr. Major speaks --
8 you can't compare group rates and individual rates together.
9 I think it was you who suggested it was sort of pears and
10 apples. They are not comparable, not the same thing. Excuse
11 me.

12 MR. MAJOR: Mr. Chairman, there are two funda-
13 mental approaches involved and it is very difficult without
14 a great deal of study to make these comparisons. It is true,
15 as far as I am concerned, and I must speak for myself, that
16 the insurance industry doesn't have a carrier in it who would
17 go out and offer to an individual in the province the coverage
18 for physician services comparable to Schedule A without some
19 kind of proof that this was a reasonable piece of business.
20 I don't think it is fair to say that nobody is doing this because
21 for the last three years we have had two non-profit doctor-
22 sponsored plans offering this kind of thing in various areas
23 throughout the province. At the present time there are 17
24 counties in this Province where people are enrolled in a
25 plan of coverage that is better than Schedule A and the price is



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16 for physician services comparable to Schedule A without some



1 \$11.80 per quarter for a family. These people are enrolled
2 whether in bed in a hospital or where they are. At the present
3 time neither one of these non-profit plans are going broke,
4 as it were. I grant there is no profit, no dividends to be
5 paid. They are still existing and I think that this should
6 be clarified. This has been going on in the province. It may
7 be daring, but it has been going on.

8 MR. NAYLOR: Were you correct in the figure
9 of \$10.80 per quarter?

10 MR. MAJOR: I am sorry, per month.

11 DR. BUTT: Was it taken on an individual basis
12 only or did 60% of the community have to be enrolled if you
13 were accepted in this?

14 MR. MAJOR: No, sir.

15 DR. BUTT: Any individual anywhere at any
16 price?

17 MR. MAJOR: That is correct. The individual,
18 and when we say individual we mean that six-year-old orphan,
19 he is an individual and he must be covered. We have to find
20 somebody to take the guardianship and responsibility of
21 covering him.

22 MR. WHITNEY: Does each one pay his premiums
23 direct? Excuse me, Mr. Chairman.

24 MR. MAJOR: Each one pays his premium on a quarterly
25 basis and the quarterly price is \$35.40. That is per family.



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1 For a single individual the price is \$10.75 a month.

2 THE CHAIRMAN: I think the question we were
3 discussing here started with Mr. Simon's question.

4 MR. SIMON: I didn't want to get into a debate
5 with P.S.I. I am not favouring either one of them.

6 MR. BERRY: I think, sir, that is a very good
7 example of the fact where you have a multiplicity of carriers
8 you have all kinds of systems tried out to get health coverage
9 to the people of Ontario. As Mr. Major has said they have
10 gone down certain avenues. We have used others. We have
11 found those of real benefit.

12 MR. SIMON: I am concerned with money because
13 people are going to be paying the money.

14 MR. BERRY: They will pay for the cost of
15 their medical care and it doesn't matter which way it is done.
16 There will still be the doctors' bills to be paid.

17 MR. MULROONEY: I think it should be observed
18 that P.S.I. is a doctor-sponsored plan and have the advantage
19 of an 11% subsidy by the medical profession, by the doctors,
20 which the other carriers don't have. This also affects the
21 picture.

22 THE CHAIRMAN: What I would like to draw the
23 attention of the Enquiry is to the fact we are not here attempting
24 to fix these rates.

25 MR. BERRY: No, sir.



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1 THE CHAIRMAN: These rates are only examples
2 that are suggested.

3 MR. SIMON: I realize that.

4 MR. BERRY: Might Mr. Watson make one more
5 comment without appearing to get into a debate?

6 MR. WATSON: I started to answer Mr. Simon's
7 question if that maximum premium was too high. I just wanted
8 to comment by saying it is about the same, or, I think perhaps
9 a little lower than Medicall which is a well-known plan being
10 offered to the people of Ontario and it is being sold at that
11 rate today. It isn't out of line with what is being done in
12 the sale of individual policies. I wanted to also say my
13 statement to which Mr. Major rebutted was intended to refer to
14 someone who comes into your office and doesn't have any partic-
15 ular county or something of that kind. I am aware of group
16 enrollments or community enrollment procedures. I wasn't
17 referring to them. I am quite aware of them.

18 MR. SIMON: Isn't it also true the larger the coverage
19 the lower the premium, the more people participating it will
20 reduce the premiums. If it is anticipated another million
21 people in Ontario will join the medical insurance after Bill
22 163 is in force, it should help to reduce, not increase the
23 premiums.

24 MR. WATSON: We would hope so.

25 MR. SIMON: On page 2 of the brief . . .



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MR. SIMON: On page 2 of the brief . . .



1 MR. BERRY: You are past the roman numbers and
2 on to the regular numbers?

3 MR. SIMON: Back to the regular numbers. Page
4 2 of your brief you suggest the organizational structure as
5 a Co-ordinating Directorate, the Medical Carriers Incorporated
6 and a Review Committee. I can't find anywhere in these three
7 set-ups any representation by the consumers. In every case
8 you have representatives of the insurance companies. In one
9 of them doctors are represented and in none of them the people
10 who are going to pay money for the insurance in this Province
11 have any representation.

12 MR. BERRY: In the case of the two bottom
13 committees, these are technical committees, the Review Committee,
14 and the Medical Carriers Incorporated. They are concerned with
15 matters of technique. In the case of the Co-ordinating Director-
16 ate it has a chairman, a representative of the Minister who
17 would surely be there to look after the interests of the people
18 of Ontario.

19 MR. SIMON: He will be outnumbered seven to
20 one.

21 MR. BERRY: He happens to be a very potent man,
22 just the same.

23 THE CHAIRMAN: They suggest in the Medical Carriers
3 24 Incorporated a neutral chairman to be appointed by unanimous
25 consent of the directors. Whether he could be appointed by the



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1 directors and still be neutral is a question, but they suggest
2 a neutral chairman.

3 MR. SIMON: Surely it's not a person who chairs
4 the meeting? He doesn't vote, and he only votes in the case
5 of a tie, and he would be neutral and only have a vote in the
6 case of a tie.

7 MR. BERRY: I believe that Mr. Major's Board
8 carries representation of the public. Is that right sir?

9 MR. SIMON: You should have been here yesterday.

10 MR. CASWELL: Not indirectly will the consumer
11 be represented, but I'm reasonably sure that he will be
12 directly represented.

13 MR. WHITNEY: Don't leave that point without
14 giving me a chance, Mr. Chairman.

15 MR. BERRY: In many of these things we put
16 forward suggestions. We are by no means saying that these are
17 final solutions.

18 THE CHAIRMAN: Is it satisfactory to you,
19 Mr. Simon, for Mr. Whitney to ask questions now?

20 MR. SIMON: Yes.

21 MR. WHITNEY: I would like to make more or
22 less a comment before the question. As you know, you are well-
23 aware, and we are too, that in the legislative debates, both
24 by the proponents of the government plan, and certainly by the
25 opponents of it, there's been a great deal of discussion as to



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aware, and we are too, that in the legislative debates, both
by the proponents of the government plan, and certainly by the
opponents of it, there's been a great deal of discussion as to



1 representation on the control of such a plan as this, and it's
2 come out in probably extreme statements that the insurance
3 companies were running it completely themselves, and so on and
4 so forth. That's one point.

5 The other point is that we've had fairly strong
6 representations to us on what the composition of these
7 suggested boards that you have charted on page 2 in your
8 suggestions -- we've had variations of that presented to us,
9 all the advisory boards, and what-not, and I think we've had
10 enough representation to us that there seems to be a problem
11 that this Committee is going to have to consider and recommend
12 on, if it feels that it should recommend on it. It certainly
13 will discuss it in its subsequent meetings, that probably a
14 wider representation might clear away the criticisms that have
15 arisen and might meet the representations that have been made
16 to this particular Enquiry. That we will have to deal with it,
17 probably, in some form, or try to, and in order to get some
18 sort of consumer type representation.

19 Now, I don't know what form that's going to
20 take. We haven't had discussion of it, but there's been
21 suggestion that probably there should be an expansion of the
22 Board, with representations from strictly the business field,
23 as apart from the insurance business field, the commercial
24 business field.

25 There's been a suggestion that labour should be



1 represented here, and then there's been this broad term, consumer
2 representation. I don't know exactly what that ties itself
3 down to, but it probably means as much to you as it did to us.
4 I think the reason for it is that they feel that
5 in a number of these things that will have to be discussed, that
6 they aren't purely technical and administrative, and that they
7 do come into the social overtones of the whole plan, and the
8 considerations in that respect, the political social effect,
9 if you like, or result, and to illustrate what I mean, on your
10 page 4 you've mentioned Medical Carriers Incorporated, and
11 under (1), (2), (3) and (4), having said up above in paragraph
12 7 its functions are purely technical and administrative, you
13 come down to (1), (2), (3) and (4), and it's felt that the
14 setting of maximum premiums is really policy-making; that enrol-
15 ment periods, certainly on the open enrolment period, is a
16 policy thing too. We know how that works, but that there
17 might be some social gain, or social benefit desired to have
18 subsequent enrolment periods, not necessarily stated on an
19 arithmetic basis, but just because the social need seems to be
20 to encourage more people to enrol; and qualifications for
21 membership in M.C.I.; and ~~certainly of pooling~~ arrangements, and
22 all the questions that come up there.

23
24 I believe that people who have made representations
25 feel that these aren't purely technical and administrative matters,



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I believe that people who have made representations
feel that these aren't purely technical and administrative matters



1 but they do, and I know that it's hard to make a distinction,
2 I'm quite aware of that, that they do flow over into the area
3 of policy, and such policy as is of the interest to all the
4 people of Ontario, and not just the insurance people and
5 doctors who are, of course, the two main elements involved in
6 these things.

7 So my question now is, would there be any
8 real objection if we should consider, and this is only my
9 personal view, it's not any view of this Enquiry, if we should
10 consider the expansion of this Board, and possibly something
11 varying your suggestion of objects in M.C.I., so that we could
12 get a wider representation? How they would be appointed, I
13 don't know. Perhaps by the Minister, but something along that
14 line, where we can, say, compromise the opposing views.

15 Would this bother you very much?

16 MR. BERRY: This seems to me to be taking in
17 a very broad field, sir, about which we could probably talk
18 for a long time.

19 As I said in the beginning, in putting forward
20 our suggestion we don't necessarily think this is going to be
21 the final form. It's quite parallel to what has gone on in
22 Alberta, so that as time goes along, at least we have something
23 working out there that may give some idea as to whether this
24 is going to be satisfactory.

25 When you come to say that this should be broader,



1 The first thing I want to say is that I am very glad to see
2 the Government of Ontario has taken this step. I think it is
3 a very good thing that the Government has decided to do this.

4 people of Ontario, and not just the insurance people and
5 doctors who are, of course, the two main elements involved in
6 these things.

7 So my question now is, would there be any
8 real objection if we should consider, and this is only my
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23 working out there that may give some idea as to whether this
24 is going to be satisfactory.

25 When you come to say that this should be broader,



1 that in itself I don't think presents any objection, but I do
2 think that you have to bear in mind that if you are going to
3 establish a set of benefits, you certainly can't have somebody
4 who is going to decide a price who has no responsibility or
5 interest for the results.

6 Merely to take a very far-fetched example, suppose
7 you had a board which decided that they wanted to have this
8 package of benefits, but nobody should pay more than two dollars
9 a month for it? This would be a fine decision, but there
10 would be no carrier to do it, so you have to have a balance
11 in this.

12 MR. SIMON: There are provisions for arbitration
13 though.

14 MR. BERRY: That's right.

15 MR. WHITNEY: What I'm thinking about, and
16 the extreme example that you give is well within our knowledge,
17 that we couldn't see anything carrying on in such a way that
18 it would cause extreme difficulties, or someone else would
19 have to pick up the Bill. The fund would quite readily reflect
20 insolvency at the end of the year, but there's precedent
21 for it.

22 As you know, in the constitution of the board
23 of directors of life insurance companies, under the Canadian
24 and British Insurance Companies Act they only allow four officers
25 who are internal men in the insurance companies to be on the



1. The first thing I should mention is that the committee has been very busy in the last few months.

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3. who is going to decide a price who has no responsibility or
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21. of directors of life insurance companies, under the Canadian
22. and British Insurance Companies Act they only allow four officers



1 board, and the remaining members of the board, nine to twenty-
2 one, are assembled from members of the business community
3 generally, from different fields and so on.

4 It is because there is a feeling, I think, and
5 always has been, that the operation of life insurance funds,
6 and the policy premiums collected, is something in the nature
7 of a trust, and I think there's a feeling in the representations
8 that have come to us that this thing that is now coming into
9 being is something too in the nature of a public trust.

2 10 MR. BERRY: It's somewhat different, of course,
11 than the board of directors, which is directly responsible for
12 the management of an individual organization. This, of
13 course, lays down a set of conditions under which carriers
14 of various kinds are going to be permitted to operate it, and
15 it's not quite analogous, but, as I said in the beginning, I
16 don't think of necessity that anything with a different composition
17 necessarily would produce any objection on our part.

18 THE CHAIRMAN: I think that question has probably
19 been answered. We can probably get back to Mr. Simon.

20 MR. SIMON: On page 17, you speak about the
21 identification of the resident who requires subsidization.

22 Now, what do you mean by that? Does it mean
23 a means test, or a special identification card? What's the
24 purpose of the grading of persons?

25 MR. BERRY: No, I think the words mean you have



1
2
3
4 It is because there is a feeling, I think, and
5 always has been, that the operation of life insurance funds,
6 and the policy premiums collected, is something in the nature
7 of a trust, and I think there's a feeling in the representations
8 that have come to us that this thing that is now coming into
9 being is something too in the nature of a public trust.
10 MR. BERRY: It's somewhat different, of course,
11 than the board of directors, which is directly responsible for
12 the management of an individual organization. This, of
13 course, lays down a set of conditions under which terms
14 of various kinds are going to be permitted to operate it, and
15 it's not quite analogous, but, as I said in the beginning, I
16
17
18 THE CHAIRMAN: I think that question has probably
19 been answered. We can probably get back to Mr. Simon.
20 MR. SIMON: On page 17, you speak about the
21 identification of the resident who requires subsidization.
22 Now, what do you mean by that? Does it mean
23 a means test, or a special identification card? What's the
24 purpose of the grading of persons?
25 MR. BERRY: No, I think the words mean you have



1 to decide who the people are who require subsidy. It's not
2 intended as a sort of a label on it. It was merely to say
3 this is the group of people, not to identify people individually.

4 MR. SIMON: You don't mean that he has to come
5 to the doctor with a card to show that he's a second-class
6 citizen?

7 MR. BERRY: Not as far as we're concerned, sir .

8 MR. SIMON: Okay, thank you. On page 21 you
9 are suggesting here which group of people should be subsidized,
10 and then you say that people that aren't required to pay income
11 tax would be the people who would be subsidized and from there
12 on they have to pay for their own insurance.

13 That's the meaning?

14 MR. BERRY: In effect, sir, yes. Again, this
15 is merely a suggested dividing line.

16 MR. SIMON: Well, we had the same discussion
17 with the other people the other day, not mentioning names, and
18 I'm still anxious to know how a person, or family, with depend-
19 ents, can afford to pay for their insurance at the basis of
20 about twenty-three, twenty-four hundred dollars a year income,
21 which is the level of starting to pay income tax?

22 MR. BERRY: Might I make two comments to that
23 sir? If the State decides that a family receiving, whatever
24 the level of dollars, should be taxed, surely the State at
25 this point must have decided that they are able to be self-



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21 which is the level of starting to pay income tax?

22 MR. BERRY: Might I make two comments to that

23 sir? If the State decides that a family receiving, whatever

24 the level of dollars, should be taxed, surely the State at

25 this point must have decided that they are able to be self-



1 supporting, or it shouldn't be taking away part of their
2 income.

3 Now, we merely say this is a possible level.
4 The government may decide that they don't like our suggestion
5 at all. They may think it should be higher, or lower. We
6 merely put forward a possible mechanism by which this could
7 be done.

8 There isn't any magic number, Mr. Simon, but
9 we start off, though, as I say, on the assumption that the
10 State surely shouldn't take money away from the citizen who
11 can't support himself.

12 MR. SIMON: When he starts to pay income tax
13 for his next thousand dollars, he's probably paying ten, which
14 is a hundred dollars, and you want him to pay one hundred and
15 fifty dollars for insurance.

16 Now, you aren't suggesting here that that's
17 fair?

18 MR. BERRY: You must set a boundary, sir, and
19 no matter where you set it, you've always got the problem of the
20 man who is five dollars under it, as opposed to the man who is
21 five dollars over it.

22 MR. SIMON: Now, on the Appendix II, on page
23 2, item (e), at the top of the page "guaranteed renewable",
24 you suggest that the individual has a right to renew his
25 contract under the terms of this Act, and conditions and maximum



at all. They may think it should be higher, or lower. We merely put forward a possible mechanism by which this could be done.

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no matter where you set it, you've always got the problem of the man who is five dollars under it, as opposed to the man who is five dollars over it.

MR. SIMON: Now, on the Appendix II, on page

2, item (e), at the top of the page "guaranteed renewals",

You suggest that the individual has a right to renew his

contract under the terms of this Act, and conditions and maximum



1 subscriptions enforced for such contract at the date of renewal.

2 Does it mean that if I'm paying a certain rate,
3 and then fall out, and wish to renew my policy, you can then
4 charge me the maximum rate if you wanted to?

5 MR. BERRY: Let me see if I understand the
6 problem you pose, Mr. Simon. You are a man who has a policy
7 with one of our carriers?

8 MR. SIMON: Right.

9 MR. BERRY: And for some reason you have this
10 at a low premium, which is below the maximum?

11 MR. SIMON: Yes?

12 MR. BERRY: For some reason you do not continue
13 your policy. You go away for a year, or two years, or whatever
14 it is, and you come back, and at this moment you now come to
15 make a new contract. Unless there is a new open enrolment
16 period, and should there be one of those, then the original
17 conditions would apply, but you might be charged the maximum
18 premium. You might have come back quite a different risk. You
19 might have gone and let your premium lapse. You have something
20 serious happen to you, and you say "Now I think I'll go back
21 and begin to pay premiums again."

22 This is rather like a man who, having seen his
23 house catch fire, runs around the corner and wants to know if
24 they won't issue a fire insurance policy on the house.

25 MR. SIMON: Yes, but I might also have left my



119

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serious happen to you, and you say "Now I think I'll go back

and begin to pay premiums again."

This is rather like a man who, having seen his

house catch fire, runs around the corner and wants to know if

they won't issue a fire insurance policy on the house.

MR. SIMON: Yes, but I might also have left my



1 job, or been unemployed for six months, and I want to renew
2 my policy, and then you can, if you want to, charge me a
3 higher rate, or up to the maximum rate under the wording of
4 this?

5 MR. BERRY: This is possible, sir, if there was
6 a break in the coverage.

7 MR. SIMON: I don't think that's the intent
8 of Bill 163.

9 THE CHAIRMAN: Do I interpret your statement
10 here correctly to mean that using for instance myself as an
11 example, if I had a policy with you that, let us say, is beyond
12 the minimum, and I reach the age of 65, I'm guaranteed on
13 being able to continue this policy, or can you cancel that
14 and give me the minimum policy only, make the minimum policy
15 only available to me?

16 MR. BERRY: Do you mean the Schedule B policy?

17 THE CHAIRMAN: Yes?

18 MR. BERRY: No sir, but the question of how
19 your premium rate will be is a matter for the particular type
20 of contract which you have bought. In Mr. Major's organization,
21 for example, you might have a flat premium for life. You might
22 have that with one of our carriers. You might have a premium
23 where the rate changed.

24 THE CHAIRMAN: But it is my impression that
25 Bill 163, as it's drafted now, would not guarantee having the



1 I am not sure that I have not already said this, but I am not sure.
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6 a break in the coverage.

7 MR. SIMON: I don't think that's the intent
8 of the bill.

9 THE CHAIRMAN: Do I interpret your statement
10 as saying that you are not sure that the bill is
11 intended to cover the whole thing, or is it
12 intended to cover the whole thing, or is it
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14 intended to cover the whole thing, or is it
15 intended to cover the whole thing, or is it

16 MR. BERRY: Do you mean the Schedule B policy?
17 THE CHAIRMAN: Yes.

18 MR. BERRY: No sir, but the question of how
19 you would want to handle the Schedule B policy
20 of contract which you have brought. In Mr. Major's organization,
21 for example, you might have a first premium for life. You might
22 have a first premium for life. You might have a first premium
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26 THE CHAIRMAN: But it is my impression that
27 it is dated now, would not guarantee having the
28 rate changed.



1 policy which you had continue on the basis which you had after
2 sixty-five?

3 MR. BERRY: What do you mean on the basis?

4 THE CHAIRMAN: Would not guarantee it being
5 available for continuation at the rate which has been established.

6 MR. BERRY: No, that's not necessarily so.

7 MR. WATSON: It would be continuous, but not ---

8 THE CHAIRMAN: But not at the rate you've been
9 paying?

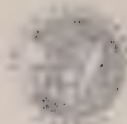
10 MR. WATSON: At the maximum.

11 MR. MAJOR: Do I conclude from your remarks that
12 it would be possible for a member of the C.H.I.A. to institute
13 step rates, where another member of the C.H.I.A. could not
14 institute step rates?

15 There was a little bit of sophistication in a
16 statement you made that did not click with me. You said you
17 might get it from one carrier, but not from another, and you
18 excluded the non-profit plan.

19 Do you anticipate a situation where certain
20 members of the C.H.I.A. could implement step rating, and certain
21 members could not, or do you envisage a situation where, through
22 M.C.I., all licensed carriers would either implement step
23 rates or not implement them?

24 MR. WATSON: Well, we envisage a situation where
25 every carrier would be free to institute whatever rate he thought



1 every carrier would be free to institute whatever rate he thought
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 19 available for continuation at the rate which has been established
 20 THE CHAIRMAN: Would not guarantee it being
 21 MR. BERRY: What do you mean on the basis?
 22



1 was best for his business, either community-rated, or some other
2 system, and we would prefer, if possible, to have complete
3 freedom in that regard, but most of our members would probably
4 select a system which would have either a flat rate, or a system
5 of a rate depending upon the age at which the policy was
6 issued, but increasing at age sixty-five.

7 That's what most of our members would think of.

8 In other words, a single step at age sixty-five, but there
9 would be complete freedom in that regard, and it would depend
10 upon individual company decisions, and we have no idea what
3 11 these would be.

12 MR. SIMON: I think, Mr. Chairman the public
13 has different ideas about Bill 163. They think that once a
14 person is insured and he leaves a job, or retires, he's going
15 to be maintained, or be able to continue his policy at the
16 same rate, even though he is sixty-five, or whatever rate --

17 MR. WATSON: If we had issued a policy at three
18 dollars a month, you say that Bill 163 would prevent us, if
19 we felt that we would have to, by the nature of the risk, increas-
20 ing it to the maximum?

21 MR. SIMON: Yes, Bill 163 says that policies
22 shall be renewable, or maintained, or continued.

23 MR. WATSON: Yes, but not at the same rates though.

24 MR. MAJOR: How are you going to reconcile
25 that with the clause in the Bill that only gives you the



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MR. WATSON: How are you going to reconcile



1 option of increasing your rates by class? That an individual
2 taking out this policy, as he grows older could find himself
3 being billed for a different rate? This wouldn't be covered,
4 or I don't think you would have this privilege under the
5 clause of the Bill that says you can't change a premium unless
6 you do it for the whole class at that particular time. So that
7 there's a protection in here for the citizen, that you could
8 not willy-nilly apply step rates to the individual citizen,
9 so that a policy bought at 45 in 15 years could become a
10 maximum rate, unless this were done on a class basis.

11 MR. WATSON: We would think of age as a class.
12 When people became 65, we think it would be quite appropriate
13 to call it a class.

14 THE CHAIRMAN: I think we're getting into a
15 debating situation, rather than clarification.

16 MR. WHITNEY: I'm not clear on the fact that
17 Section 18(1)(a), where it says class-risk basis --
18 what is the meaning of class-risk basis to you? That you might
19 have thirty to forty; forty to fifty, fifty to sixty-year class,
20 and as an individual contract comes up for renewal, you could
21 reclassify the individual, and put him in another class, where
22 he might have a higher premium?

23 MR. BERRY: There are two different kinds of
24 situations, sir. Situation one is the situation where a person
25 buys a contract in which the premium arrangements are stipulated.



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2 being billed for a different rate? This wouldn't be covered,
3 or I don't think you would have this privilege under the
4 clause of the Bill that says you can't change a premium unless
5 you do it for the whole class at that particular time. So that
6 there's a protection in here for the citizen, that you could
7 not willfully apply step rates to the individual citizen,
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16 Section 18(1)(a), where it says class-risk basis --

17 what is the meaning of class-risk basis to you? That you might

18 have a class-risk basis, or is it a class-risk basis?
19 I'm not clear on the fact that
20 Section 18(1)(a), where it says class-risk basis --

21 MR. BERRY: There are two different kinds of

22 class-risk basis, one is the class-risk basis, and the other is the individual risk basis.



1 Those arrangements would be carried out, because they are
2 part of the original contract. This clause says that you cannot,
3 because of the fact that losses have been inordinately heavy,
4 pick out George Berry's contract and charge him an extra
5 premium as an individual, just one or two or three, but if
6 there was a necessity for a rate adjustment it must be done
7 on some class basis. For example, all the policies you issued
8 in the year 1964, if this was where your inordinate group
9 was, or all your policies of type X, but you can't pick one
10 person and make a rate adjustment that's not in the contract.
11 That's part of the original --

12 MR. WHITNEY: In other words, it's class of
13 contract, rather than class of individual?

14 MR. BERRY: It might be either, but you cannot
15 select an individual and say "You've had a lot of claims, Mr.
16 Whitney, and therefore we're going to change your premium, and
17 yours alone".

18 MR. MAJOR: This class proposition is very
19 versatile, and as far as I'm concerned I think it would be
20 very helpful if somebody in the C.H.I.A. would write up a short,
21 concise approach to class as far as separating is concerned,
22 and how the class would be affected in time, say three or
23 four years, so that we could have some idea in this Enquiry
24 as to the ramifications of this particular Section of the Act.

25 MR. WATSON: I think we can promise to do that for



1 Those arrangements would be carried out, because they are
2 part of the original contract. This clause says that you cannot
3 because of the fact that losses have been inordinately heavy,
4 pick out George Berry's contract and charge him an extra
5 premium as an individual, just one or two or three, but if
6 there was a necessity for a rate adjustment it must be done
7 on some class basis. For example, all the policies you issued
8 to some class of business, if you had a heavy loss, you would
9 have to adjust the rate for that class of business.
10 person and make a rate adjustment that's not in the contract.
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12 MR. WHITNEY: In other words, it's a class of
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22 and then we would be able to adjust the rate for that class.
23 MR. WATSON: I think we can promise to do that to



1 you.

2 MR. MAJOR: And setting forth enough of the
3 various classes to show what it means.

4 THE CHAIRMAN: I would like to point out one
5 thing to the Members of the Enquiry here, if I may. There's
6 a possibility that we may be obliged to limit this hearing
7 today, and ask them to come back, if they so wish.

8 I have said that we would go on to one-fifteen,
9 and we have the Ontario Medical Association here this afternoon.
10 If we start with them at two-thirty, and run through to around
11 six o'clock, they would have only the same time that we have
12 given to the delegation here this morning.

13 So, in view of this, I suggest that we let
14 the two people, Mr. Simon who still has the floor here carry
15 on. Mr. Whitney has, according to our schedule here, the
16 floor following him. Let him complete it, and then we will
17 open it up for other questions from other members of the
18 Enquiry.

19 MR. SIMON: On page 11, 11a, on top of the page,
20 paragraph 18, still on the Appendix II, right on top of the
21 page, paragraph 18(a), you suggest:

22 "Any carrier may from time to
23 "time adjust the rate of subscription ---".

24 Now, this is again deviating from the intent of
25 the Bill, which says that the initial period will be two years,



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"Any carrier may from time to

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the Bill, which says that the initial period will be two years,



1 and then once a year. Do you want to leave it at the discretion
2 of the insurance companies at any time to adjust, which in
3 high language means going up, not going down?

4 MR. DREWRY: The opening words say that after
5 two years.

6 MR. SIMON: I stand corrected. So that after that
7 it may be done at any time. There's no limit, not just once
8 a year?

9 MR. BERRY: Just to take a hypothetical situation,
10 suppose that costs of medical care in Ontario were suddenly
11 changed, the doctors' schedule of fees, for example, might have
12 to be changed to reflect economic conditions. Now, this
13 immediately offers the benefits which you have undertaken to
14 pay, and there must be some provision so that your premium,
15 if necessary, can follow the benefits.

16 You might hopefully look forward to a day when
17 you might be able to reduce the premiums because the incidence
18 of illness and so on was reduced.

19 MR. SIMON: This has not been the experience
20 for the last 25 years.

21 MR. BERRY: This is quite true sir, quite true,
22 but I would like to register a point that just because it
23 happens to be that that is the way things have gone that an
24 adjustment of the premiums would conform to the experience,
25 and obviously you aren't going to do this every time you turn



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and obviously you aren't going to do this every time you turn



1 around.

2 MR. SIMON: But the person who buys the policy,
3 or the group, are interested in some stability, and they want
4 to have at least a year or two.

5 MR. BERRY: It seems to me that in there
6 someplace there's an arrangement that there has to be given
7 notice, and so on, but as I say, you must have something, sir,
8 to adjust to changing conditions from time to time, if it was
9 to be say once a year, or something in this order, but you
10 have got to have it so that both sides of the bargain can be
11 kept in adjustment. If you premise the benefit for certain
12 costs, you can't have the benefits changed out from underneath
13 you.

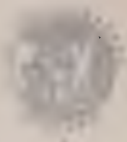
14 MR. SIMON: In other words, this would go into
15 the small type would it?

16 MR. BERRY: There's no small type, sir. I would
17 like to correct that.

18 MR. SIMON: Thank you.

19 MR. WHITNEY: I think I just have two questions,
20 Mr. Chairman.

21 In Appendix II of your suggestions of amendment
22 to Bill 163, I see that you have pretty well carried through
23 a number of amendments on your redraft. I can see that a lot
4 24 of the amendments have to do with mentioning dropping the
25 in-hospital Schedule B, and bringing in the co-insurance contract.



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or the group, are interested in some stability, and they want to have at least a year or two.

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to Bill 100, I see that you have pretty well carried through a number of amendments on your behalf. I can see that a lot

of the amendments have to do with mentioning dropping the

hospital Schedule B, and bringing in the co-insurance contract



1 On your first page, in Section 1(d)(ii) you
2 stop at nineteen years of age for the family coverage with
3 respect to dependents.

4 Do you think this could be widened to cover
5 dependents above nineteen who are still at university and
6 unable to pay their own -- truly a dependent, and not a wage-
7 earner?

8 MR. BERRY: We used age nineteen because, as
9 I recall it, this is the age in the Ontario Hospital Services
10 Act, and if you have a child in university, on the day at
11 age nineteen you get a bill from the Ontario Hospital Services
12 Commission, and this was really a dividing line that was
13 already accepted.

/MR/RPS 14 MR. WHITNEY: The other thing that bothers
15 me in that dependent definition is that the person must be
16 physically infirm before 19. What happens if the child becomes
17 physically infirm and dependent at 20?

18 MR. BERRY: At this point he will have become
19 a holder in his own right, which again would follow the
20 Ontario Hospital Services Commission, if my memory is correct.

21 MR. WHITNEY: That answers that. In connection
22 with your suggested amendments on Section 4 of the Act, this
23 carries through for the next two or three pages, and this is
24 a general question now: You note that it is provided that
25 those selling medical service insurance contracts are to be



On your first page, in Section 1(d)(ii) you

stop at nineteen years of age for the family coverage with

respect to dependents.

Do you think this could be widened to cover

dependents above nineteen who are still at university and

unable to pay their own -- truly a dependent, and not a wage-

MR. PERRY: We used age nineteen because, as

I recall it, this is the age in the Ontario Hospital Services

Act, and if you have a child in university, on the day at

age nineteen you get a bill from the Ontario Hospital Services

Commission, and this was really a dividing line that was

MR. WITNEY: The other thing that bothers

me in that dependent definition is that the person must be

physically infirm before 19. What happens if the child becomes

MR. PERRY: At this point he will have become

a holder in his own right, which again would follow the

Ontario Hospital Services Commission, if my memory is correct.

MR. WITNEY: What answers that. In connection

a general question now: You note that it is provided that

those selling medical service insurance contracts are to be



1 members of Medical Carriers Incorporated. This seems to imply,
2 or probably it provides -- goes that far -- that being licensed
3 and being a member of M.C.I. the conditions of operating in
4 the field, that the membership might conclude that they must
5 be in the pooling. Am I correct in that in the redraft of
6 those three pages that the effect of it is that being a member
7 of Medical Carriers, a condition of being able to operate in
8 the field would also mean that that carrier would have to be
9 included in the pooling?

10 MR. BERRY: Unless exempt under some opting out
11 arrangement which would enter into it.

12 MR. WHITNEY: Have you suggested any opting out
13 arrangements in the redraft or are we to look at that?

14 MR. BERRY: If you look at the last sentence on
15 Section 5, sir, this would be part of the pooling arrangements
16 that we negotiate if this program comes into being.

17 MR. WHITNEY: So a carrier must be licensed by
18 the Superintendent and be a member of M.C.I., and a voting member
19 but may be allowed to opt out of pooling?

20 MR. BERRY: Yes sir.

21 MR. WHITNEY: Therefore, not be liable for these
22 assessments having to do with the pooling losses?

23 MR. BERRY: Yes sir. This pooling, it seems to
24 be a problem that comes up and on which there seems to be a
25 great deal of difficulty. The concept is quite simple I think,



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21 MR. WHITNEY: Therefore, not be liable for these
22 assessments having to do with the pooling losses?
23 MR. BERRY: Yes sir. This pooling, it seems to
24 be a problem that comes up and on which there seems to be a
25 great deal of difficulty. The concept is quite simple I think,



1 but we admit that the technique of working out the necessary
2 arrangements is a rather complicated business of mathematics
3 so that everybody is treated fairly. As Mr. Watson said where
4 you have a carrier who, by reason of the composition of its
5 business has already taken care of a large proportion of high
6 cost risk, then they have to have some credit so that this
7 pooling assessment is fair, and this is something that you can't
8 sort of discuss in its detail in a hearing like this. This
9 is something you have to get people who are technicians in the
10 business, to sit down together and work out.

11 MR. WHITNEY: Thank you. That is all I have.

12 THE CHAIRMAN: Do any other members of the
13 Enquiry have any questions? Dr. Hamilton?

14 DR. HAMILTON: Mr. Berry could you tell me
15 please in paragraph 41, page 18 you state: There are two
16 categories of residents eligible for government assistance. At
17 the end of that paragraph, on page 19 you state that if the
18 government desires and the medical profession concurs, benefits
19 identical with those provided by the standard medical services
20 contract could be made available to those persons now under the
21 Ontario Medical Welfare Plan, and the last sentence:
22 Such an arrangement would be outside the operation of the
23 program in Bill 163. Would you tell me why? I don't understand
24 this recommendation.

25 MR. BERRY: I think this is one area in the brief



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sort of discuss in its detail in a hearing like this. This
is something you have to get people who are technicians in the
business, to sit down together and work out.

MR. WHITNEY: Thank you. That is all I have.

THE CHAIRMAN: Do any other members of the

body have any questions? Dr. Hamilton?

DR. HAMILTON: Mr. Berry could you tell me

please in paragraph 4, page 13 you state: There are two

categories of residents eligible for government assistance. At

the end of paragraph 4, page 13 you state: At the

present time, the only category of residents eligible for

government assistance is the category of residents who

are unable to support themselves. Is that correct?

MR. BERRY: Yes, that is correct.

Such an arrangement would be outside the operation of the

program in Bill 163. Would you tell me why? I don't understand

this recommendation.

MR. BERRY: I think this is one area in the bill



1 on which we made a comment because we thought it rounded out
2 the picture of an area which has been well taken care of by
3 arrangements between government and the medical profession.
4 The only reason we put the comment in there was that we thought,
5 if we did not, the Committee might think that we felt that the
6 existing arrangement under the Medical Welfare Plan I think
7 its name is, should be left for that group of people and they
8 should have no consideration as far as broader benefits are
9 concerned. We were merely pointing out that if the government
10 and the profession decided they could alter that arrangement
11 so that the same type of benefits would be available to that
12 group of people as well as to everybody else in Ontario and had
13 some such arrangement that they had now rather than changing
14 the basic plan which you have.

15 DR. HAMILTON: Would this not separate this
16 group of people and segregate them and put them into a different
17 class?

18 MR. BERRY: Certainly not any more than they
19 do now Doctor.

20 DR. HAMILTON: Thank you.

21 DR. BUTT: To follow that point, if asked, would
22 you be in a position to work out some type of arrangement that
23 carried this particular group?

24 MR. BERRY: I think insurance carriers sir could
25 work out an arrangement to carry any particular group but since



1 I think the only way to handle this is to have a
2 committee to look into it and report back to the
3 committee. I think that is the only way to handle
4 it. I think that is the only way to handle it.
5 I think that is the only way to handle it.
6 I think that is the only way to handle it.
7 I think that is the only way to handle it.

8 should have no consideration as far as broader benefits are
9 concerned. We were merely pointing out that if the Government
10 and the profession decided they could alter that arrangement
11 so that the same type of benefits would be available to that
12 group of people and segregate them and put them into a different
13 group. I think that is the only way to handle it.
14 I think that is the only way to handle it.

15 DR. HAMILTON: Would this not separate this
16 group of people and segregate them and put them into a different
17 group?
18 MR. BERRY: Certainly not any more than they
19 do now Doctor.

20 DR. HAMILTON: Thank you.
21 DR. BUTT: To follow that point, it asked, would
22 you be in a position to work out some type of arrangement that
23 carried this particular group?

24 MR. BERRY: I think insurance carriers sit could
25 have had some arrangement to carry any particular group that



1 you are going to wind up in the plan with a purely Governmental
2 group, as opposed to a private citizen, we thought that the
3 Government itself would not be regarding this as a politically
4 palatable sort of approach to the problem.

5 DR. BUTT: If the Government did feel this
6 should be covered, would you be in a position to do that, or
7 to have it administered through M.C.I., or something of that
8 nature? Do you feel you could give us details of how that might
9 be done?

10 MR. BERRY: I think this could be done sir. If
11 a specific proposition was made, carriers are prepared to look
12 at any group of risks and make any proposition.

13 DR. BUTT: Then put it this way: Suppose one
14 would say that this is potentially possible, would you be prepared
15 to submit for this Enquiry details of how this might be done at
16 least?

17 MR. BERRY: I am not at all sure we could on
18 the information we have got now but certainly we would put our
19 minds to it and see if we could come up with -- in other words,
20 it might be quite possible to do it under the general arrange-
21 ments. We certainly have not put our minds to it.

22 MR. CASWELL: May I make a comment on this?

23 DR. BUTT: I am not saying this is possibly the
24 Bill, but this is one phase.

25 MR. CASWELL: Mr. Berry, if he could supply this



Group, as opposed to a private citizen, we thought that the Government itself would not be regarding this as a politically

should be covered, would you be in a position to do that, or to have it administered through M.C.I., or something of that

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MR. BERRY: I am not at all sure we could on

MR. CARROLL: May I make a comment on this

DR. BUTT: I am not saying this is possibly the



1 information, I think he should supply us with some suggestion
2 as to what the cost would be because I believe, it is our
3 information now that is handled through the Ontario Medical
4 Association under the Government and Welfare Department and the
5 doctors accept now approximately 78% of the cost of their
6 fee.

7 MR. BERRY: Obviously you will have to tell
8 us what the benefit is you want us to pay.

9 MR. CASWELL: On the plan they are getting now,
10 they are being paid only 78% of their fee.

11 MR. BERRY: And this only covers a certain type
12 of medical cost, so obviously -- are you asking us to quote
13 for this group on the basis of plan A in the Act at the full
14 tariff? Is that what you are saying?

15 DR. BUTT: I think you would have to consider
16 it first, anyway.

17 MR. BERRY: May we make a request then? Would
18 the Committee arrange to have somebody set this request down
19 in its exact terms so that when we sit down to do the arithmetic,
20 we don't start ---

21 MR. SIMON: I don't think the Committee has
22 decided to give more business to the insurance companies, as
23 far as this group is concerned. I don't think anybody here
24 is urging the Committee to do business with insurance companies.

25 THE CHAIRMAN: I think what has been suggested that



MR. BERRY: Obviously you will have to tell

us what the benefit is you want us to pay.

MR. CASWELL: On the plan they are getting now,

they are being paid only 75% of their fee.

MR. BERRY: And this only covers a certain type

DR. BUTT: I think you would have to consider

MR. BERRY: May we make a request then? Would

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in its exact terms so that when we sit down to do the arithmetic

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THE CHAIRMAN: I think what has been suggested that



1 you might provide here requires quite a bit of work on your
2 part. I think rather than at this time making this specific
3 request of you, we would wait until we get into a discussion
4 and then when we decide, if we do, this would be helpful, we
5 can make it then. We appreciate your co-operation.

6 MR. BERRY: It looks as though we put a comment
7 in here sort of to round out the picture that started the
8 discussion. If we hadn't done, it wouldn't have got going.

9 THE CHAIRMAN: Mr. Major?

10 MR. MAJOR: Thank you Mr. Chairman. Mr. Berry
11 on page 1 of the summary and recommendations, in paragraph 4,
12 the last three lines:

13 ". . . the health insurance business pledges
14 "itself to co-operate with the medical profession
15 "and other suppliers of health care. . . " and
16 so on. Now I am only asking this question because you said
17 "other suppliers of health care". We have been pressed in
18 this Enquiry by many submissions that Bill 163, as it now
19 stands, is not nearly comprehensive enough or sufficient for
20 the citizens of the Province. I gather from what you say in
21 paragraph 4 that you would be quite prepared to go farther
22 and make arrangements with para-medical people if the Govern-
23 ment so wishes.

24 MR. BERRY: No sir. As you are well aware
25 the insurance companies do not confine themselves solely to the



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2 part. I think rather than at this time making this specific
3 request of you, we would wait until we get into a discussion
4 and then when we decide, if we do, this would be helpful, we
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7 in here sort of to round out the picture that started the
8 discussion. If we hadn't done, it wouldn't have got going.

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10 MR. MAJOR: Thank you Mr. Chairman. Mr. Berry

11 on page 1 of the summary and recommendations, in paragraph 4,
12 the last three lines:

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17 "other suppliers of health care". We have been pressed in

18 this industry by many submissions that Bill 163, as it now

19 stands, is not nearly comprehensive enough or sufficient for

20 the citizens of the Province. I gather from what you say in

21 paragraph 4 that you would be quite prepared to go further

22 and make arrangements with para-medical people if the govern-

23
24 MR. BERRY: No sir. As you are well aware



1 provision of medical service -- insurance against medical
2 service. We, for example, under comprehensive medical plans
3 cover such things as nurses, drugs, prophylactic appliances,
4 this kind of thing. We have members who have contracted
5 who do provide for payment to people other than physicians,
6 and in the statement of our policy we were merely alluding
7 to the fact that we do not restrict, we are not restricted to
8 just medical care as this Enquiry is in its considerations
9 of Bill 163 but we do not, of necessity, sort of say we take
10 in all para-medical groups.

11 MR. MAJOR: I have a loaded question Mr. Berry.

2 12 MR. CHAIRMAN: Aren't most of yours?

13 MR. BERRY: Thank you for the warning.

14 MR. MAJOR: On page 5 of the recommendations,
15 item 3:

16 "There shall be no compulsion upon anyone

17 "to purchase or acquire coverage."

18 As an insurance executive, handling a great
19 deal of group coverage would you agree that there is a sort
20 of compulsion in group coverage ?

21 MR. BERRY: I think this all depends. This all
22 depends on what you mean by "a sort of compulsion".

23 MR. MAJOR: Let me try and explain myself. When
24 you go into a group, where you say we will do all these things
25 under certain conditions. We will make a contract with the



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1 consideration of medical services in the various medical groups
2 existing. But, my colleague, Mr. Macdonald, has introduced a bill
3 which would bring in a new medical group, the paramedical group.
4 This group of course, the paramedical group, would be a new group
5 and it would be a group of people who are not physicians,
6 and in the language of our bill, we have stated that
7 to the fact that we do not restrict, we are not restricted to
8 just medical care as this Bill is in its considerations
9 of Bill 163 but we do not, of necessity, sort of say we take
10 in all para-medical groups.

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12 MR. CHAIRMAN: Aren't most of yours?

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16 "to purchase or acquire coverage."

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18 deal of group coverage would you agree that there is a sort

19 of compulsion in group coverage?

20 MR. BERRY: I think this all depends. This all

21 depends on what you mean by "a sort of compulsion."

22 MR. MAJOR: Let me try and explain myself. When

23 you go into a group, where you say we will do all these things

24 we will have a contract with the



1 employer provided the employer pays so much money to the
2 coverage and that we get at least 75% of the employees. This
3 is broad terms.

4 MR. BERRY: Yes.

5 MR. MAJOR: Would you say this is a slight, just
6 a little bit of compulsion on the citizens?

7 MR. BERRY: No sir, because you might have a
8 group where only 72% of the people decided to enrol, and then
9 we would not issue the contract, if that was one of the
10 conditions under which we had said we would.

11 MR. MAJOR: Do you think that after your state-
12 ment made sometime ago that it would be very necessary for
13 some control to be placed on all carriers, even if you had to
14 set up this control on a basis of, let us say, they must accept
15 a commission to do the job ---

16 MR. BERRY: I beg your pardon. What do you mean
17 by a commission to do the job?

18 MR. MAJOR: A paid amount to enrol people on an
19 individual basis.

20 MR. BERRY: Yes sir.

21 MR. MAJOR: You must get these people excited to
22 do the job. Would you think that some form of compulsion, maybe
23 just a little bit throughout this Bill, would be beneficial
24 for the statistical averaging of an insurance principle to
25 meet a reasonable charge, maybe lower than the maximum rate?



1 employer provided the employer pays so much money to the

3 is broad terms.

4 MR. BERRY: Yes.

5 MR. MAJOR: Would you say this is a slight, just

6 a little bit of compulsion on the citizens?

7 MR. BERRY: No sir, because you might have a

9 we would not issue the contract, if that was one of the

10 conditions under which we had said we would.

11 MR. MAJOR: Do you think that after your state-

12 ment made sometime ago that it would be very necessary for

13 some control to be placed on all carriers, even if you had to

15 a commission to do the job ---

16 MR. BERRY: I beg your pardon. What do you mean

17 by a commission to do the job?

18 MR. MAJOR: A paid amount to enrol people on an

20 MR. BERRY: Yes sir.

21 MR. MAJOR: You must get these people excited to



1 MR. BERRY: I think at this point sir you are
2 asking me for a personal opinion. I am not saying this represents
3 the view of the Association, or I cannot even speak for the
4 people at this table. This is a personal opinion. I happen to
5 have an abhorrence of compulsion on the citizens in a democracy.

6 MR. MAJOR: Thank you. On page 8 of your
7 recommendations, I am going to try to explain this, and to do
8 this I will talk to you. As I understand what you said or what
9 is suggested in your brief, there are approximately 116 insur-
10 ance carriers who will be offering some type of contract under
11 Bill 163 to the public.

12 MR. BERRY: I don't think that is quite right.
13 I think we said we had 116 members. It may be though some of
14 them may decide that they do not want to issue this type of
15 coverage.

16 MR. MAJOR: Let us accept 75. Now you have said
17 here that each carrier will use his own approach. He will be
18 free to do his own underwriting as he sees fit.

19 MR. BERRY: Yes.

20 MR. MAJOR: It has come up in a couple of
21 questions and answers. Now in your proposition of a maximum
22 rate, this maximum rate has been set knowingly below the
23 profit-making standpoint, the break-even point. We have had
24 several presentations to us ---

25 THE CHAIRMAN: You said it has been set. It has

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1 not been set.

2 MR. MAJOR: Theoretically, to all intents and
3 purposes this has been set based on a break-even rate, so there
4 will be a loss of 10¢ per person. Now each carrier is going
5 to set a rate based on some kind of standard whereby the
6 underwriter can determine, to some degree, the insurance risk
7 in this person?

8 MR. BERRY: Yes sir.

9 MR. MAJOR: We have had presentations put to
10 us it is not fair, nor is it equitable that any insurance sold
11 under this particular Bill should have a profit element.
12 Now provided that the underwriter wishes to, is it not possible
13 that he may, as long as he does not charge the maximum rate,
14 include in his underwriting rate for an individual who has
15 filled out his questionnaire, an increment of profit?

16 MR. BERRY: Yes sir. I didn't know there was
17 anything in this Bill that said that if you were in this
18 business you could not make a profit. I would like to repeat
19 what I said before. I regard the opportunity to make a
20 profit as one of the most important forces towards keeping costs
21 low and in every organization, whether it is called such or not,
22 there is something which corresponds to it, otherwise the
23 organization, in this kind of business, could not continue to
24 exist.

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organization, in this kind of business, could not continue to



1 MR. MAJOR: In other words, profit is the basis
2 of our society.

3 MR. BERRY: That is right, and I would like to
4 repeat of all types of carriers who are in this field.

5 DR. BUTT: Mr. Chairman, just on that point,
6 have you any idea -- there has been a lot pointed out as to
7 what the word "profit" means, but this is a very profitable
8 section of your business, and, what about the tax situation
9 where you are losing money? In other words you as a corporation
10 have to pay do you not, and your profit, it gets down to such
11 a low figure -- the administrative costs of the organization,
12 regardless whether they are non-profit or whether they are
13 government, will cost a certain amount?

14 MR. BERRY: Yes sir.

15 DR. BUTT: The efficiency of the organization,
16 I think it should be brought out when you are talking about these
17 words, what it would cost or whether you feel you actually lose
18 or win very much in this particular section of your business.

19 MR. BERRY: As I said before, we fall into two
20 groups. A group of mutual companies whose job is to provide
21 protection at cost to their policyholders, they have no stock-
22 holders so that their drive again is competition; in order to
23 keep the cost to their policyholders as low as they can. The
24 stock companies, on the other hand, have a limitation on the
25 dividends they can declare which is written into the Insurance



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1 Act, and on this particular type of business I think it is fair
2 to say that if I look around at all the carriers, this has not
3 been a particularly profitable type of business.

4 DR. BUTT: Have you any estimate of what it
5 might be, or what it runs at? Does it run at a loss?

6 MR. WATSON: I anticipated your question and
7 I have some figures. For the year 1961 it would indicate over
8 the whole business in Canada a profit or a contribution to
9 surplus, in the case of mutual companies, of half of one per
10 cent.

11 THE CHAIRMAN: On that basis it carries its
12 share of the overhead?

13 MR. WATSON: Yes.

14 MR. SIMON: Is it not true when you sell this
15 kind of insurance, you can also sell other kinds?

16 MR. BERRY: Sometimes.

17 MR. SIMON: I am dealing with many companies,
18 Mr. Chairman, in negotiating labour agreements. We propose in
19 many cases other forms, and I am not going to mention names
20 at this time, of coverage and the company always comes back
21 and says we have a deal with an insurance company that gives
22 us life, gives us pensions, they give us other coverage and
23 we have to give them this part as well, so it is a package.

24 When you do business with a company, you take the good and bad.

25 MR. BERRY: Except that in our returns to the



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1 Government the non-life business must be separated out and
2 the expenses must be appropriately apportioned, and this is
3 true in the group field. It is not true in the individual
4 field where you sell the contract.

5 MR. SIMON: That is true.

6 MR. WATSON: The figure is taken from the reports
7 of the Superintendent of Insurance of Canada.

8 MR. MAJOR: Now on this underwriting business
9 of the individuals, I think it is well known it is formed
10 on the non-profit, prepaid plans, community rated where the
11 insurance industry traditionally has experience rating, and
12 this experience rating is the result of this type of under-
13 writing approach. Now what have you got against the proposition
14 of rather than underwriting individuals, setting a maximum
15 rate following the non-profit organization approach of
16 community rating them all, and putting them all into a pool,
17 having your charge-backs then a very simple calculation. This
18 is the only method you have been able to devise to excite
19 insurance companies to sell this, is this true?

20 MR. BERRY: No sir.

21 MR. MAJOR: Then can you explain to us why you
22 are picking on this particular method of allowing individual
23 underwriting, with a questionnaire which must be filled in by
24 the individual rather than setting a rate and don't worry about
25 his age or his health condition or anything else? Why not put it



time in the group field. It is not true in the individual

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MR. BERRY: No sir.

MR. MAJOR: Then can you explain to us why you



1 that way and pool everybody?

3 2 MR. BERRY: If I might make a try at answering
3 that question, I believe that the people of Ontario will be
4 best served by a multiplicity of methods. I do not think that
5 any one of us can say that a particular method is the best way
6 to do it and this Association holds that view, that this is
7 an essential part of spreading this protection over as many
8 people as we can in Ontario. Now what you are proposing is
9 that in this particular field everybody should become a service
10 plan. Now I do not think that is good. If you take group
11 business, which is something of the order of seven-eighths,
12 if my memory is correct, of all the business, we do form a
13 community rate so that to that extent we have a community rating
14 on smaller groups than you do, so that we are sort of a
15 combination. I think one of the very important things is that
16 if you community rate, you may not be able to attract one who
17 will decide this is too much to pay. I think there should be
18 more than one way of this being done. I do not think everybody
19 should be forced into one particular mold. I do not think that
20 is how you are going to make improvements in our system and
21 how you are going to get people insured.

22 You may feel quite differently. As I said,
23 this is our view.

24 THE CHAIRMAN: Mr. Berry, pardon me for inter-
25 jecting a question here, can you give us some reasons why you



1 That was all right.

2 MR. BERRY: If I might make a try at answering

3 that question, I believe that the people of Ontario will be

4 best served by a multiplicity of methods. I do not think that

5 any one method is the best. I think that the best method is

6 the one that is most adapted to the needs of the community.

7 I am sure that the people of Ontario will be best served

8 by a multiplicity of methods. Now what you are proposing is

9 that in this particular field everybody should become a service

10 plan. Now I do not think that is good. If you take group

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20 is how you are going to make improvements in our system and

21 how you are going to get people insured.

22 You may feel quite differently. As I said,

23 That is all right.

24 THE CHAIRMAN: Mr. Berry, pardon me for inter-

25 posing a question here, can you give us some reasons why you



1 people thought it is desirable for the group of indigent people
2 -- you do suggest in your brief, I was looking for the place
3 and couldn't just put my finger on it, I think the indigents
4 under Schedule C, you suggest we carry on under the Ontario
5 Welfare Act. Is that right?

6 MR. BERRY: This is the question which Dr.
7 Hamilton asked and we inferred, because we sort of rounded out
8 the picture, we looked as though we wanted to sort of suggest
9 a solution to a problem that is the Government's.

10 THE CHAIRMAN: The Act suggests that these be
11 under the carriers rather than under that plan. My question
12 is not based on that. The Act which is here, and you understand
13 that while we have the responsibility of filling in the details
14 of this Act, and so forth, we also had an opportunity to
15 consider and recommend many things beyond that. What is the
16 advantage, in your opinion, of common carriers insuring this
17 indigent group, and the age 65 and over, and the poor risks
18 assuming that eventually you are going to work up to a very
19 high percentage of the people in this group being covered by
20 subsidized insurance or insurance that they buy rather than
21 the government being in the insurance business itself and
22 paying the cost of these indigents?

23 MR. BERRY: If I may restate the question sir,
24 to be sure I understand it.

25 THE CHAIRMAN: I think I confused it a bit.



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22 paying the cost of these indigents?

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24 to be sure I understand it.

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1 MR. BERRY: We at no point have suggested that
2 we should pay the carrier for the indigents, and we are talking
3 about the people now who are under the Medical Welfare Plan.

4 THE CHAIRMAN: The Act I think does suggest doesn't
5 it though that the carriers would include the indigents here
6 as mentioned?

7 MR. BERRY: I did not understand this was the
8 arrangement which permitted the Minister to continue the plan
9 which he has at the present time. I admit rereading it it
10 looks as though he can go out and purchase it anywhere he likes.
11 Obviously if he has an agreement with the doctors that they
12 will make this service available at some very substantially
13 reduced fee, then unless you are going to get other kinds of
14 fee schedules for the benefit of this group, you could not
15 compete by offering them a hundred per cent.

16 THE CHAIRMAN: This may be a misinterpretation
17 on my part but it looked to me as though the Act here, and I
18 have no official interpretation of this from any member of the
19 Government, sets it out so that the indigents under Schedule C
20 would be carried by subsidized insurance.

21 MR. BERRY: That was not our interpretation.
22 It was our interpretation sir that it was purely in there to
23 enable the government to do what is provided.

24 THE CHAIRMAN: There has not been any discussion
25 of this among the members of the Enquiry. Do you think there are



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enable the government to do what is provided.

THE CHAIRMAN: There has not been any discussion

of this among the members of the Faculty. Do you think there are



1 good reasons to get away again from government carrying on that
2 program -- I am getting into deep water here, I realize --
3 carrying on with a program similar to the Ontario Welfare Plan,
4 if they are going to pay full cost of insurance? Don't you
5 think that there is a possibility, or do you think that there
6 is a possibility that the government could do this for less
7 money by paying the medical cost of this group assuming that
8 they pay the full medical costs?

9 MR. BERRY: Once again sir you mean that rather
10 than having an insurance contract with carriers, that they
11 should just pay the medical bills? This is a very difficult
12 question to answer sir because this basically is not an insur-
13 ance problem, as you so clearly explained. This is a political
14 problem with overtones of provincial level, municipal level.
15 It involves relations with the medical profession and really
16 I don't think we should answer the question.

17 THE CHAIRMAN: Were there any further questions
18 from the members of the Enquiry? Dr. Galloway?

19 MR. MAJOR: May I finish my quote?

20 THE CHAIRMAN: I don't think Dr. Galloway has
21 had an opportunity to ask any questions. We have only three
22 minutes left here according to our schedule. We might run over
23 a bit. I don't think we can go very far beyond it.

24 MR. GALLOWAY: Mr. Chairman, Mr. Major was
25 questioning and I am quite willing to leave it to him.



1 I have been asked to ask the Minister of Health whether he is
2 carrying on with a program similar to the Ontario Welfare Plan,
3 if they are going to pay full cost of insurance? Don't you
4 think that there is a possibility, or do you think that there
5 is a possibility of the Government being able to pay the
6 money by paying the medical cost of this group assuming that
7 they pay the full medical costs?
8 MR. BERRY: Once again sir you mean that rather
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1 MR. MAJOR: Let's get down to page 9 of the
2 recommendations and here we are talking about, the last couple
3 of lines in the first paragraph to Schedule A: with a co-insur-
4 ance and deductible arrangement ---

5 MR.BERRY: This is on page regularly numbered
6 9?

7 MR. MAJOR: No, this is 9 of the recommendations,
8 the small Roman numeral nine. Now co-insurance and deductibles,
9 particularly the co-insurance has been criticized by several
10 people that have made presentations to us on the basis that
11 this kind of insurance should not be put out to the public
12 because it automatically precludes all the normal preventive
13 services that would ordinarily be included in any type of plan
14 that would be sponsored or get government sympathy. Is there
15 not a fair amount of co-insurance sold by the insurance industry
16 and could not the insurance industry continue to sell that even
17 though it was not a standard plan, and eliminate this from the
18 schedule? Wouldn't this be a possibility?

19 MR. BERRY: Yes, I think it would. I would
20 like to make a comment, if I may on this. There is a good
21 deal I think of misunderstanding about co-insurance and
22 deductibles and the trouble with the Schedule A benefits for
23 the people who are self-supporting, of course, is it becomes
24 a mixture of budgeting and insurance and when you speak of such
25 things as annual health examination, and well-baby visits, for

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MR. BERRY: Yes, I think it would. I would

like to make a comment, if I may on this. There is a good

deal I think of misunderstanding about co-insurance and

deductibles and the trouble with the Schedule A benefits for

the people who are self-supporting, of course, is it becomes



/PB/rps.

1 example, those in our view would better be handled by the
2 family as part of the family budget, just as they provide
3 food, clothing and shelter and the co-insurance keeps the
4 cost of this down. If you assume that there is the same level
5 of medical care for all families, to pick a figure, say
6 \$25 or \$50 there isn't very much sense in giving \$50 to an
7 insurance company or any carrier to have them give you the
8 same \$50 back because you are only going to get it as far as
9 your family budget. I think there is room for both approaches
10 and it is borne out by the fact, as I said before Mr. Major's
11 organization is very difficult competition and he carries
12 about half of this business so about half of the people in
13 Ontario seem to like first dollar coverage and we do very well
14 with co-insurance and deductible. We have done very well.

15 MR. MAJOR: Really this is a little outside
16 the point but preventive medicine has been one of the key points
17 of practically every presentation to us. It has even been
18 suggested by other bodies rather than the medical profession,
19 preventive medicine is just not a health examination or is it
20 well-baby care, it is the intangibles, it is the training
21 that a doctor gives and so on and so forth to people. All
22 the deductible proposes to do here is to deter to some extent
23 that this would become automatic for the citizens of the
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25 Most of those people making presentations to us



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1 feel it should become automatic that this would be a limited
2 feature rather than a deterrent to it. My main proposition
3 is there is no reason why it couldn't be left out of the
4 insurance business really, and held separately as another
5 piece of insurance.

6 MR. WATSON: If I may answer this, the present
7 Bill does provide Schedule B which gives an alternative plan
8 at a somewhat lower rate. We wanted to recommend an alternative
9 at some lower rate which wouldn't have the disadvantages we
10 see in Schedule B. We think it is desirable to have two such
11 plans. Your question is if it was left out you could still
12 sell them if you wished to do so, and the only objection we
13 would see to that is in a pooling arrangement we need to have
14 a standard plan, otherwise it can't be pooled.

15 If it was left out all such contracts couldn't
16 be pooled and that wouldn't be a satisfactory situation from
17 our standpoint.

18 MR. MAJOR: I agree, that is correct. There
19 is no reason that it can't be handled on the marketplace?

20 MR. WATSON: No, other than that.

21 MR. MAJOR: In the same event, and I ask the
22 question with full knowledge you wanted to delete Schedule B,
23 in your presentation of the Alberta situation you don't tell us
24 the breakdown between our Schedule A and the deductible schedule
25 that has been approved in Alberta. I am going to give a statement



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17 our standpoint.
18 MR. MAJOR: I agree, that is correct. There
19 is no reason that it can't be handled on the marketplace?
20
21 MR. WATSON: No, other than that.
22 MR. MAJOR: In the same event, and I ask the
23 question with full knowledge you wanted to delete Schedule B,
24 in your presentation of the Alberta situation you don't tell us
25 the breakdown between our Schedule A and the deductible schedule
26 that has been approved in Alberta. I am going to give a statement



1 that is pure gossip. It might incite you to give me the answer
2 I am looking for. I understand that out of 19,000 contracts
3 taken up in the Province of Alberta under the medical approach
4 there were only 57 people that bought the deductible premium.
5 Is that so?

6 MR. WATSON: I am not familiar with gossip,
7 Mr. Major. We will have to let our expert on Alberta answer
8 that question.

9 MR. BERRY: As it turned out it isn't terribly
10 far from the truth. You have to remember that the vast majority
11 of people who come forward and the whole purpose of the Alberta
12 plan was that the vast majority of people who came forward
13 were people aged or those who couldn't carry on any medical
14 bills at all. I think it is very interesting that so far
15 at least there has been no sign of any major shift in all the
16 group which is in force with deductions and co-insurance which
17 is on the group or population, that did pre-exist.

18 MR. MAJOR: You didn't anticipate there would
19 be.

20 MR. BERRY: No, and I don't anticipate there
21 will be.

22 MR. MAJOR: The final question is this: Do you
23 see any reason to build up an administrative setup to legislate
24 such a plan with only 57 people out of 20,000, 100 people out
25 of 20,000 and how do you deal with the 100 people?



1 That is pure gossip. It might incite you to give me the answer
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13 bills at all. I think it is very interesting that so far
14 at least there has been no sign of any major shift in all the
15 group which is in force with deductions and co-insurance which

16 MR. MAJOR: You didn't anticipate there would

17 MR. BERRY: No, and I don't anticipate where

18 MR. MAJOR: The final question is this: Do you
19 see any reason to build up an administrative setup to legislate
20 such a plan with only 57 people out of 20,000, 100 people out
21 of 20,000 and how do you deal with the 100 people?



1 MR. BERRY: If we stay at the one hundred
2 level this is a serious problem. I go back to my basic state-
3 ment, and I would hope that the Committee is persuaded of the
4 benefits to be derived from a competitive system, a multiplicity
5 of carriers and multiplicity of plans. I think it would be
6 unfortunate if the Act as it was designed was, in fact, a
7 pressure to force everybody to one particular mold.

8 MR. MAJOR: The competitive system allows you
9 to sell anything you want. You are not forced to sell only the
10 standard plan.

11 MR. BERRY: You would then have a set of
12 ground rules which gives advantages to the standard plan
13 intending to push everybody in the same direction.

14 MR. MAJOR: I will pass over some of my
15 questions.

16 THE CHAIRMAN: You did say that was your final
17 one.

18 MR. MAJOR: That is the final one on that
19 particular point.

20 THE CHAIRMAN: Mr. Major, in all seriousness
21 how long are you going to be?

22 MR. MAJOR: I think three or four minutes. I
23 will screen these out.

24 Paragraph 3 of the brief, and I won't take time
25 to read the whole paragraph you come down to the sixth line from



MR. BERRY: If we stay at the one hundred

three hundred and thirty-three, I go back to my main state-

ment, and I would like to see the Committee in agreement at the

beginning of the day to have a competitive system of membership

in the service and industry of the United States. I think it would be

unfortunate if the Act as it was designed was, in fact, a

pressure to force everybody to one particular mold.

MR. MAJOR: The competitive system allows you

to sell anything you want. You are not forced to sell only the

products of the United States.

MR. BERRY: You would then have a set of

ground rules which gives advantages to the standard plan

of doing business in the United States.

MR. MAJOR: I will pass over some of my

questions.

THE CHAIRMAN: You did say that was your final

one.

MR. MAJOR: That is the final one on that

question.

THE CHAIRMAN: Mr. Major, in all seriousness

how long are you going to be?

MR. MAJOR: I think three or four minutes. I

will screen these out.

Paragraph 3 of the brief, and I won't take time

to read the brief, but I will read the first line of



1 the bottom and you say:

2 "The right to apply for exemption would

3 "not apply to pool (2)".

4 Pool (2) is for persons over 65. I would gather
5 from the questions and answers that have come out here today
6 you are advocating considering the opting out procedure on the
7 pool for over 65?

8 MR. BERRY: Yes.

9 MR. MAJOR: Is this compatible with the statement?

10 MR. BERRY: We think the pooling arrangement,
11 Mr. Major, and I think I said it before, and I would like to
12 repeat it if I may, the principles of the pooling, the reasons
13 for the pooling are, I think, quite simple to accept. The
14 technique of the pooling has quite different forces and
15 requires a great deal of calculation by people who are going
16 to work out arrangements that will satisfy carriers, hopefully
17 the doctor-sponsored plans, insurance companies, carriers --
18 all those in the pooling arrangement. There is a successful
19 approach.

20 MR. MAJOR: The point I am making, Mr. Berry,
21 in your questions and answers as a member of this Enquiry I
22 took it for granted you were quite prepared and were recommend-
23 ing to some extent that there would be an opting out process
24 available to certain carriers for pool 65. I think your
25 statement makes it definite that this wouldn't be so, but I



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"not apply to pool (2)".

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took it for granted you were quite prepared and were recommend-
ing to some extent that there would be an opting out process
available to certain carriers for pool 65. I think your
statement makes it definite that this wouldn't be so, but I



1 wanted to make sure the Enquiry realizes the situation.

2 MR. BERRY: Excuse me, sir, I don't think we
3 recommended. We said it was a possibility that could still
4 be considered. I don't think we made a recommendation that
5 contradicted this.

6 MR. MAJOR: I used the word implied when you
7 answered the question. It could be gathered.

8 THE CHAIRMAN: I don't think we will debate the
9 issue.

10 MR. MAJOR: Next you say "This is essentially
11 the arrangement which has been adopted in the Province of
12 Alberta". Unless, in fact, the draft approved by the
13 Lieutenant Governor on June 25th has been changed whereunder
14 regulation 4 of paragraph 3 it said that Alberta Medical
15 Carriers Incorporated may exempt any approved carrier either
16 wholly or partly from participation in the pooling arrangement" --

17 Has that been changed?

18 MR. BERRY: No.

19 MR. MAJOR: There is an exemption setup in the
20 Alberta system.

21 MR. BERRY: Yes, but I don't think it is
22 contradictory. It is the sense of the arrangement.

23 MR. NAYLOR: It is true no carrier has been
24 exempted.

25 MR. BERRY: In Alberta no carrier so far as I am



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1 I cannot be sure that the English version is correct.

2 MR. BERRY: Excuse me, sir, I don't think we

3 recommended. We said it was a possibility that could still

4 be considered. I don't think we said it was recommended.

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15 Carriers Incorporated may except any approved carrier either

16 locally or outside the Province in the same manner as

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19 MR. MAJOR: There is an exemption setup in the

20 Alberta system.

21 MR. BERRY: Yes, but I don't think it is

22 contradictory. It is the sense of the arrangement.

23 MR. MAJOR: It is true no carrier has been

24 MR. BERRY: In Alberta no carrier so far as I am



1 aware intends to apply for exemption in the over age 65 pool
2 and the point was never raised.

3 MR. MAJOR: It is in the legislation that they
4 may do so if they wish to do so. Isn't that the main point?

5 THE CHAIRMAN: I think, Mr. Major, we are
6 going to have to close this off with one more question.

7 MR. MAJOR: Mr. Berry, I am going to slip one
8 in. In Appendix 1 you state that the annual premiums to
9 your member companies are approximately \$187 million. I
10 placed a note in the margin it is approximately \$70 million
11 in Ontario. Is that too far out?

12 MR. BERRY: I am sorry, where are you?

13 MR. MAJOR: The first page in Appendix 1. You
14 state what the C.H.I.A. is and you get down in the data and
15 I made a note of a question that Ontario is \$70 million of the
16 \$187 million spent in Canada.

17 MR. BERRY: Unless somebody here has the figure
18 in his head I am afraid I haven't. I looked around for the
19 man that might have it twice. I am sorry I don't have it.
20 It is in the insurance book.

21 MR. MAJOR: On page 22, the last question, four
22 lines down:

23 "We suggest that these persons should be
24 "given a fixed dollar subsidy in an amount which
25 "would pay a substantial portion of their premium".



"would pay a substantial portion of their premium



1 Have you any thoughts of what is going to happen
2 or how you would handle a proposition of a group of people
3 employed whose income is such that their personal exemption
4 is greater than their income for tax purposes? Would these
5 people in employed groups regardless of whether or not the
6 employer is paying part of the cost of the plan for them, in
7 fact, be eligible for this subsidy?

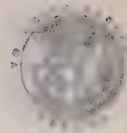
8 MR. BERRY: I think that basically the government
9 will have to decide themselves when it writes its regulations.
10 I think, for example, you could have

11 a) the situation under which the employee
12 who is under the group program is so well-off
13 he won't be interested in applying for the
14 subsidy, and

15 b) the other type of case where he might
16 decide the subsidy was worth more than staying
17 in the group and walk out and buy an individual
18 contract.

19 MR. MAJOR: In other words if a citizen approaches
20 your office you don't care where he works, if he can satisfy
21 the regulations and get a subsidy then you would sell it to
22 him whether he worked at Canadian General Electric or
23 any place else?

24 MR. BERRY: Yes, subject to the fact that there
25 is a double cover limitation, that you don't have people buying



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or how you would handle a proposition of a group of people

is greater than their income for tax purposes? Would these

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him whether he worked at Canadian General Electric or

MR. BERRY: Yes, subject to the fact that there



1 two sets of policies so every time they go to the doctor's
2 they get double the doctor's bills. I think that is in the
3 Act someplace.

4 MR. MAJOR: That is right. We are going to
5 have to catch them.

6 THE CHAIRMAN: Gentlemen, I am quite confident
7 that there are other questions that members of the Enquiry
8 would like to ask you, and it can very easily happen that
9 when we arrive at our discussion periods there may be questions
10 arise where we will only be able to get the answer by referring
11 back to you. I expect that we would have the privilege of
12 doing that.

13 MR. BERRY: Yes, sir.

14 THE CHAIRMAN: Rather than carrying on this
15 hearing further at the present time and cutting short the
16 other delegation we are going to hear this afternoon I am
17 taking the privilege as Chairman to close it off here with
18 the understanding that we may be coming back to you if we feel
19 it desirable to do so. Is there any statement you would like
20 to make?

21 MR. BERRY: Simply to thank you for the courtesy
22 of all the members of the Board and for the opportunity of
23 coming and speaking before you. We hope it did a little to
24 help with this very complicated and onerous task you have
25 been given. Our office, you know is downtown. We would be



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18 of all the members of the Board and for the opportunity of
19 coming and speaking before you. We hope it did a little to
20 help with this very complicated and onerous task you have
21 been given. Our office, you know is downtown. We would be



1 glad to give you any information at any time from there
2 and would most certainly welcome the opportunity to come back
3 if the Committee of Enquiry think we could contribute to your
4 deliberations.

5 THE CHAIRMAN: Thank you very much.. May I
6 have one word with the delegates who are here from the Ontario
7 Medical Association. We have found it a little difficult to
8 get back during a one-hour lunch. I had mentioned to you,
9 Dr. Atkinson, we would try to be back by 2:30. If you count
10 on quarter to three we will be able to make it by that time.

11

12 ---Luncheon Adjournment.

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1 I am not sure that we have any more to say at this time.
2 I am not sure that we have any more to say at this time.
3 If the Committee of Inquiry think we could contribute to your
4 investigation.

5 THE CHAIRMAN: Thank you very much. May I

6 give you some information about the Medical Association.
7 Medical Association. We have found it a little difficult to
8 get back during a one-hour lunch. I had mentioned to you,
9 Dr. Atkinson, we would try to be back by 2:30. If you count
10 on quarter to three we will be able to make it by that time.

11

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A/PE/dpw 1 --- On resuming at 2.45 p.m.

2 THE CHAIRMAN: Ladies and gentlemen, we are
3 still missing the odd person from our Enquiry here, but I
4 think we will get underway.

5 Dr. Atkinson, would you like to introduce your
6 associates and then carry on, please?

7

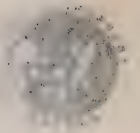
8 SUBMISSION OF THE ONTARIO MEDICAL ASSOCIATION

9 Appearances: R.D. Atkinson, M.D.
10 R.S. Duggan, M.D.
11 P. Bruce-Lockhart, M.D.
12 G.W. Mylks, M.D.
13 W.J.S. Melvin, M.D.
14 Glenn Sawyer, M.D.

15 DR. ATKINSON: Mr. Chairman, members of the
16 Medical Services Insurance Enquiry: I would like to introduce
17 the delegates from the Ontario Medical Association.

18 On my immediate right, Dr. Glenn Sawyer, our
19 General Secretary. On my far right, Dr. Gordon Mylks, Chair-
20 man of our Board. On my immediate left, Dr. Bruce-Lockhart,
21 Past President of the Association, and, next to him, Dr. R.S.
22 Duggan, the Vice-President. On my extreme left, Dr. Melvin,
23 who is a member of our Board and sits there as a representative
24 of the four medical schools in the province.

25 At the close of the morning session, Mr. Chair-
man, you made a slight slip. You suggested that the next
candidates - and corrected it to delegates. I must say that we



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THE CHAIRMAN: Ladies and Gentlemen, we are

still missing the odd person from our Endury here, but I

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MEMBERS OF THE BOARD OF MEDICAL SERVICES

- Dr. Atkinson, M.D.
- Dr. Bruce-Lochhart, M.D.
- Dr. Glenn Sawyer, M.D.
- Dr. R.S. [illegible], M.D.
- Dr. [illegible], M.D.
- Dr. [illegible], M.D.

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On my immediate right, Dr. Glenn Sawyer, our

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who is a member of our Board and sits there as a representative

of the four medical schools in the province.

At the close of the morning session, Mr. Chair-

man, you made a slight slip. You suggested that the next

association - and suggested it to ourselves



1 do feel somewhat like candidates appearing for our oral before
2 our superiors.

3 However, we appreciate this opportunity of
4 appearing before you and presenting, in some detail, the
5 studies of the Medical Association as it applies to Bill 163.

6 We have a keen awareness of the magnitude of
7 the task that has been set for you cloaked, I would say, in
8 obscurity in the terms of reference of your committee because
9 as we, in the past months, have delved into the various parts
10 of the Bill and what it would mean, and carried it through to
11 its end result, I am sure that you, too, have an appreciation
12 of this task.

13 All the citizens of the province owe you a deep
14 debt of gratitude for the time and effort that you are expen-
15 ding on their behalf.

16 Some months ago - almost two years ago now -
17 we presented a brief to the Royal Commission on Health Services.
18 A copy of this brief has been placed before you as part of our
19 submission. It goes into considerable detail as to our poli-
20 cies and our thought for the future in the health care of the
21 people of Canada and in particular this province.

22 Our current submission deals in particular with
23 Bill 163 and, therefore, is rather devoid of some of the more
24 personal aspects of medical care as we understand it.

25 Our recommendations are many. There are some



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Our current submission deals in particular with

Bill 163 and, therefore, is rather devoid of some of the more personal aspects of medical care as we understand it.



1 that I think bear mentioning in particular.

2 We have suggested three standard contracts and
3 have outlined those to you.

4 We have recommended an advisory committee with
5 lay or consumer representation on that particular committee,
6 and we have outlined, in considerable detail, a method of
7 subsidization of those people whom the province deem to require
8 it.

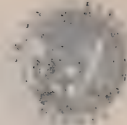
9 I would ask, sir, that any areas that require
10 clarification or amplification be outlined to us in writing,
11 following our submission, and that from the rather specific
12 detail of that we will be able to reply and assist, I hope,
13 further the study of your committee.

14 I would ask that the summaries and recommenda-
15 tions, as they are contained in our brief, be written into the
16 verbatim record that is being taken. Thank you.

17 SUMMARY

18 (i) The Ontario Medical Association is an incor-
19 porated voluntary organization with some seven thousand
20 members from all branches of medicine and all geographic
21 areas of the province.

22 (ii) Our members have been associated, for many
23 years, with the development and operation of some insuring
24 agencies and, as the providers of medical services, they have
25 had close contact with subscribers of all carriers. This



We have recommended an advisory committee with
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areas of the province.

(11) Our members have been associated, for many
years, with the development and operation of some insuring
agencies and, as the providers of medical services, they have
had close contact with subscribers of all carriers. This



1 unique experience has provided the background for this submis-
2 sion.

3 (iii) We agree with the basic principles of Bill 163,
4 and believe that the implementation of legislation based on
5 them will meet the requirements of Ontario residents.

6 (iv) The recommendations contained in our submission
7 have been made after serious consideration. We believe them
8 to be sound in principle, practical and acceptable in applica-
9 tion.

10 (v) We appreciate the magnitude of the task
11 assigned to you as commissioners of this Enquiry. On behalf
12 of our members, we thank you for this opportunity and privi-
13 lege of placing the views of our Association before you. We
14 trust they will be of some assistance as you complete your
15 deliberations.

16 RECOMMENDATIONS

17 The Ontario Medical Association recommends:

18 1) THAT there be three standard medical services
19 insurance contracts which, for purposes of clarity, might be
20 named:

21 1) Standard - with benefits of Schedule
22 A and first dollar coverage.

23 ii) Standard Deductible - with benefits of
24 Schedule A and a defined deductible and co-
25 insurance factor.

1985



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We agree with the basic principles of Bill 163.

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them will meet the requirements of Ontario residents.

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1) THAT there be three standard medical services

insurance contracts which, for purposes of clarity, might be

1) Standard - with benefits of Schedule

A and first dollar coverage.

ii) Standard Deductible - with benefits of

Schedule A and a defined deductible and co-



1 iii) Standard In-Hospital - with benefits
2 of Schedule B and first dollar coverage.
3 (paras. 15, 180, 181 and 182)

4 2) THAT carriers be required to offer the Standard
5 In-Hospital and either the Standard or Standard Deductible
6 contracts. (paras. 13 and 184)

7 3) THAT the benefits of Schedule B be enlarged to
8 include out of hospital referred consultations and diagnostic
9 services within the limits suggested. (para. 164)

10 4) THAT the benefits and exceptions of Schedule A
11 be modified as outlined. (para. 131)

12 5) THAT a carrier be permitted to issue contracts
13 other than standard contracts but where a carrier issues one
14 of the standard contracts, it be permitted by rider to the
15 contract for an additional stated premium and not otherwise,
16 to provide benefits greater than those set forth in Schedules
17 A and B. (paras. 19 and 185)

18 6) THAT all groups of self-insurers be required
19 to be licensed under this Act and to become and remain members
20 in good standing in Medical Carriers Incorporated. THAT this
21 type of carrier should not be authorized or compelled to
22 issue standard contracts to the general public. (paras. 26
23 and 184)

24 7) THAT the bill state more specifically the
25 purposes and objects of Medical Carriers Incorporated; THAT



(iii) Standard In-Hospital - with benefits

of Schedule B and first dollar coverage.

(paras. 15, 180, 181 and 182)

THAT carriers be required to offer the Standard

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issue standard contracts to the general public. (paras. 20

and 184)

7) THAT the bill state more specifically the

purposes and objects of Medical Carriers Incorporated; THAT



1 these be confined to matters of a technical nature including
2 the administration of a pooling arrangement. (paras. 98 and
3 187)

4 8) THAT the Bill establish an Advisory Committee
5 to act as an adviser to the Minister relative to the operation
6 of the initial legislation and whatever changes may be required
7 to fulfill the purposes of Bill 163; THAT its membership,
8 method of appointment, and its purposes and objects be set out
9 in the Act. (paras. 100 and 188)

10 9) THAT the Minister, on the recommendation of the
11 Advisory Committee, be authorized to suspend or cancel the
12 licence of any carrier if he deems that it is not operating
13 in the public interest or if it contravenes any provision of
14 this Act. (paras. 29 and 186)

15 10) THAT a per diem penalty be imposed on any
16 carrier that carries on business as such without a licence
17 under this Act. (paras. 30 and 186)

18 11) THAT the amounts of benefits payable under
19 standard contracts be set out more specifically in Section 17.
20 (paras. 31 and 191)

21 12) THAT the persons given total subsidy be those
22 in needy circumstances in the classes listed in Schedule C.
23 (para. 48)

24 13) THAT, for those totally subsidized:

25 1) Government insure the benefits of

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(para. 48)

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to fulfill the purposes of Bill 103; THAT its membership,

of the initial legislation and whatever changes may be required

to act as an adviser to the Minister relative to the operation

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THAT the Bill establish an Advisory Committee

187)

the administration of a pooling arrangement. (para. 98 and



1 Schedule A on a basis of first dollar
2 coverage.

3 2) Government make an arrangement with
4 the Ontario Medical Association for the
5 insurance of this group.
6 3) This arrangement be outside of Medical
7 Carriers Incorporated. (para. 83)

8 14) THAT those residents whose incomes do not
9 exceed their personal exemptions on the TD 1 income tax form
10 and who either do not meet the requirements for total subsidy
11 or choose not to apply for same, be made eligible for a
12 partial subsidy; and THAT those eligible for partial subsidy
13 be detailed in a separate schedule in the Act. (paras. 48 and
14 49)

15 15) THAT the subsidy provided to, or on behalf of,
16 those requiring partial assistance, be a fixed-dollar amount
17 not to exceed the amount of the premium. (paras. 60 and 63)

18 16) THAT any subsidy be made available only for the
19 purchase of the Standard Medical Services Insurance Contract.
20 (para. 72)

21 17) THAT the individual, applying for partial
22 subsidy, make a statutory declaration of his eligibility for
23 subsidy, to the carrier of his choice, and that the carrier
24 bill government on behalf of all subsidized residents to whom
25 it had issued Standard contracts. (para. 65)



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will government on behalf of all subsidized residents to whom

it had issued Standard contracts. (para. 65)



1 18) THAT all subsidized medical services insurance
2 contracts bear some mark or code which will make it apparent
3 to the doctor that the patient is in receipt of subsidy.

4 (para. 87)

5 19) THAT section 54 of the Public Health Act be
6 repealed; and that this legislation place upon the municipality
7 the responsibility for the insurance or payment of medical
8 services, required by needy residents, analogous to that
9 placed upon it by the Hospital Services Commission Act and
10 the regulations thereunder. (paras. 91 and 96)

11 20) THAT the board of arbitration referred to in
12 section 18(2) be changed so that:

13 1) Medical Carriers Incorporated name one
14 arbitrator.

15 2) The second arbitrator be named by the
16 Minister.

17 3) The third arbitrator, who shall be chair-
18 man, be appointed by a judge of the Supreme
19 Court. (paras. 114 and 192)

20 21) THAT a new section be enacted, reading as
21 follows:

22 "No carrier, by a medical services insurance
23 contract, shall interfere with the right of
24 an insured person to choose his own physician
25 or impose an obligation upon a physician to



18 THAT all subsidized medical services insurance

19 to the doctor that the patient is in receipt of subsidy.

20 THAT section 24 of the Public Health Act be

21 repealed; and that this legislation place upon the municipality
22 the responsibility for the insurance or payment of medical
23 services, required by needy residents, analogous to that
24 placed upon it by the Hospital Services Commission Act and
25 the regulations thereunder. (paras. 91 and 92)

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31 man, be appointed by a judge of the Supreme

32 Court. (paras. 114 and 122)

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34 follows:

35 "No carrier, by a medical services insurance
36 contract, shall interfere with the right of
37 an insured person to choose his own physician
38 or impose an obligation upon a physician to



1 treat any insured person." (paras. 118 and 194)

2 22) THAT the insurance of all medical services be
3 brought under the provision of a Medical Services Insurance
4 Act; THAT this policy be established now and implemented as
5 soon as possible: and THAT in the meantime no further encroach-
6 ment be allowed by further amendment to the regulations under
7 the Hospital Services Insurance Act. (para. 144)

8 23) THAT the suggested amendments to Bill 163, set
9 out in Part II of this submission, be incorporated in the Act.
10 (paras. 167 to 195)

11 24) THAT government give early consideration to a
12 plan whereby subsidized patients will be assured of getting
13 necessary drugs. (para. 148)

14 25) THAT preoccupation with medical services
15 insurance not delay the provision of government funds for
16 medical schools, medical teaching, schools of nursing, hospital
17 beds and the other facilities and personnel required to main-
18 tain a high standard of medical services. (para. 130)

19 THE CHAIRMAN: Thank you very much. You have
20 certainly submitted a lot of information here and provided us
21 with a great deal of reading matter.

22 I, rather facetiously, said this morning, to
23 one of my associates, that if we required an oath of anybody,
24 probably it could be taken on this.

25 I am sure that those of you who were here this

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one of my associates, that if we required an oath of anybody,

probably it could be taken on this.

I am sure that those of you who were here this



1 morning will be aware that numerous members of the Enquiry
2 will have numerous questions to ask of you. We will start those
3 off with Mr. Coulter.

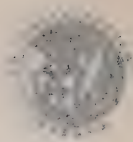
4 MR. COULTER: Dr. Hagey and gentlemen: I would
5 compliment you on your brief. As Dr. Hagey has said, it is a
6 wealth of information and plenty of reading. I tried to wade
7 through it all.

8 My first question is: would you explain to me
9 why you are recommending three coverages, particularly the
10 co-insurance factor?

11 DR. ATKINSON: Mr. Chairman, from our study of
12 the present plans available in the province, it would seem that
13 a certain percentage of people who have coverage - and we
14 estimate this at approximately 50% - like something that has
15 a co-insurance deductible factor; the other 50% like first-
16 dollar coverage and in keeping with the terms that the Govern-
17 ment have set forth, that there be a normal play of plans
18 available and people be allowed to obtain, subject to a
19 maximum premium, with specific benefits, a non-cancellable
20 form of coverage, it would seem to us wise to provide both
21 types of contracts for these people.

22 MR. COULTER: In your opinion, sir, would there
23 be any problem of administration in the co-insurance factor
24 where it might be wholly subsidized or partially subsidized by
25 the Government?

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MR. COUNTER: Dr. Hagay and Gentlemen: I would
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1 DR. ATKINSON: Mr. Chairman, we are not recom-
2 mending that the people who receive subsidy from the Government,
3 either in whole or in part, receive this type of contract.

4 We recommend that they receive the first
5 contract, first-dollar coverage.

6 MR. COULTER: Thank you. Now, I guess it is
7 on...

8 THE CHAIRMAN: Mr. Coulter, would you like to
9 refer to the page and question number?

10 MR. COULTER: Thank you. I will. On page V
11 of your Recommendations, Section 18:

12 "...that all subsidized medical services
13 insurance contracts bear some mark or
14 code which will make it apparent to the
15 doctor that the patient is in receipt of
16 this subsidy."

17 Would you tell me and this committee why this
18 is pertinent to the medical people whether a person is subsi-
19 dized or not?

20 DR. BRUCE-LOCKHART: I think the point at issue
21 is that we are anxious that these people should not be subject
22 to any additional charges beyond that paid by their insurance.
23 It is very difficult to be sure of this unless there is some
24 method by which the profession knows who they are. One can
25 make a guess at it, perhaps. We feel it would give those



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1 people much better protection if it was available - the infor-
2 mation was available - to the profession, that they were subsi-
3 dized.

4 MR. COULTER: The reason for asking this was
5 that it was my thought that the Minister was not anxious that
6 there be two classes of citizens as far as Bill 163 is
7 concerned. This sort of labels a person, does it not?

8 MR. SIMON: Isn't there a danger that there
9 would be an inferior service if there is no extra money to be
10 charged?

11 DR. ATKINSON: I would like to answer those two
12 questions separately.

13 We understand, from the Minister, that he wishes
14 all citizens to have comparable benefits available to them and
15 the designation by code or mark would not have any bearing on
16 the benefits that would be available under this Bill.

17 In answer to Mr. Simon's question, Mr. Chairman,
18 it is our understanding, from the Minister of Public Welfare,
19 Mr. Cecile, that over a long period of time there has been no
20 criticism of the operations of the medical welfare plan admini-
21 stered by our Association and these people have a card which
22 identifies them as recipients of that particular government-
23 profession plan.

24 DR. SAWYER: If I may just supplement that ques-
25 tion that Mr. Simon raised about the quantity of medical



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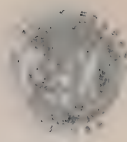
23 DR. SAWYER: If I may just supplement that ques-
24 tion that Mr. Simon raised about the quantity of medical



1 service available to people who are identified, I think every-
2 one would agree that the people on the medical welfare plan
3 are identified as receiving government assistance. And I had
4 placed on my desk just a couple of days ago some statistics on
5 the number of services per thousand recipients per month of
6 the medical welfare plan and it turned out that they were given
7 362.9 services per month per thousand in 1962. So, as a matter
8 of interest, I turned to the statement of P.S.I. for the same
9 year. Now, P.S.I. is their complete plan, in and out of
10 hospital, and they gave 423.48 services per thousand per
11 month. So if you look at what is given to the welfare reci-
12 pients for an out-of-hospital plan and compare it with P.S.I.,
13 which is a total plan, I think it would show that a great
14 number of services are, in fact, given to this specific group
15 which is identified. And if you look at the Old Age Security
16 - that is the people over 70 - you will find that they got
17 529.8 services per thousand recipients per month. In other
18 words, they got more services on a home and office basis than
19 the average in P.S.I. got for their complete plan. So there
20 is no question that the doctors provide service even though
21 they are identified.

22 MR. SIMON: As far as the older people, they
23 require more services?

24 DR. SAWYER: Yes, they require more services.
25 And when you get down to the disabled, they have 450 and the



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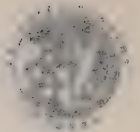
1 people over 65, 459. So it drops down to 219 on mother's
2 allowance.

3 MR. WHITNEY: If Mr. Coulter will permit me, I
4 think we are getting away from his question. His question is:
5 what is the reason for the code numbering? I think probably
6 part of the answer is that on the O.M.A. welfare plan you have
7 to have a code initial somewhere, or something, to cue you so
8 you know where to send your bill.

9 Why do you feel the same code, whether it is a
10 Z or an A that you put on the end of the numbers, would be
11 necessary with respect to the fully subsidized wage-earner of
12 the non-welfare group? Above that, do you feel some code is
13 necessary there for the subsidized or partially subsidized?

14 DR. ATKINSON: Mr. Chairman, the partially
15 subsidized, I think, are the people that we are discussing now
16 because the totally subsidized that we discuss, according to
17 our recommendations, would be covered under some plan
18 comparable to that already in effect, unless government decided
19 otherwise. But, let us discuss the partially subsidized.

20 MR. WHITNEY: I think we should clear that up.
21 The O.M.A. welfare group, as you recommend, might very well -
22 not necessarily - but it may stay out of Medical Carriers
23 Incorporated. It is not beyond the realm of possibility. We
24 do not know yet. There may be a totally subsidized group
25 above the welfare group and then there may be a partially



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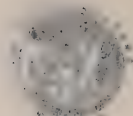


1 subsidized group. We do not know the answer to that yet, as a
2 committee. So I want to be sure that we are talking about the
3 same thing.

4 DR. ATKINSON: I think that the answer applies
5 to whether they are partially subsidized or totally subsidized,
6 that this group of people, by being identified in the medical
7 profession, have the advantage, as Dr. Bruce-Lockhart pointed
8 out, of not being subject to any additional fee over that
9 recognized, or any payment that might be made on their behalf
10 that this would cut off the liability of that particular
11 person.

12 The other fact is that in practice - and this
13 will vary from one community to another - there are community
14 services available and if the doctor knows that his patient is
15 in that area of requiring subsidy, he will call on those
16 community agencies to assist in the total health care of that
17 particular family. I am thinking of drugs. There are drugs
18 available through druggists, through some of the suppliers,
19 and so on. Transportation of the patient can be arranged. If
20 you know that he cannot provide for transportation himself
21 because he fits into this area, you can call someone who would
22 help out. Or a church organization. I think this is our point.

23 DR. BRUCE-LOCKHART: There are actually two
24 other areas: (1) I think it is probably less embarrassing for
25 the patient to have a code number than to have a doctor say,



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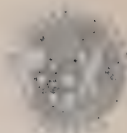
1 "Can you afford transportation?" I think there is another
2 side to this coin.

3 Then there is a second point that crops up. If
4 you take total coverage under Schedule A, there is still the
5 problem of the patient who is subsidized who elects to go to
6 a specialist directly; for instance, for obstetrical care
7 which, in our recommendation, would not be covered at the
8 specialist rate. It is much better for the specialist if he
9 knows this at the beginning of any discussion with the
10 patient in this particular instance, rather than having it
11 found out and it could be a hardship and a problem and an
12 argument later. So there is more than one side to this coin.

13 MR. COULTER: I should ask you a loaded ques-
14 tion, then, to get back to Mr. Major's coined phrase. In the
15 event that we could coax 95% of the people into some type of
16 coverage through government help, should any person be asked
17 to pay more than 100% of the O.M.A. schedule of fees for any
18 particular thing?

19 DR. BRUCE-LOCKHART: This pre-supposes that you
20 believe that total coverage can be provided at a fixed premium,
21 but one of the problems that crops up is that the demands for
22 services vary enormously from different people.

23 The second problem is that you can either insure
24 the schedule, which means that if a patient elects quite
25 unnecessarily to go to the more expensive specialist, then you



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1 are loading the premium against the people who have a family
2 doctor and only go to the specialist when it is necessary.
3 Therefore, total coverage is not possible in the sense that
4 you suggested it was, unless you are going to say that this is
5 the sort of coverage you want, which we recommend against, for
6 many good reasons.

7 The next thing is that you can't say that all
8 doctors are the same. A newly-qualified surgeon is not in
9 exactly the same category as the senior professor of surgery.
10 If you maintain that there should be no such thing as a patient
11 demanding excess service, I do not know how you are going to
12 stop him, nor if there isn't any difference between the senior
13 professor and the newly-qualified surgeon, then at this point
14 you are going to put your premium up enormously and you are
15 going to swamp the senior surgeon and you are going to kill
16 general practice.

17 So those are the reasons behind this statement.

18 MR. COULTER: I do not think you have convinced
19 me, but I will accept your answer.

20 MR. NAYLOR: Is extra-billing only done by
21 specialists?

22 DR. BRUCE-LOCKHART: No, sir. Again, if you
23 have a patient who demands an unreasonable amount of service,
24 it would seem very reasonable to charge him for the service
25 that he demands. An insurance principle, basically, gives you



are loading the premium against the people who have a family doctor and only go to the specialist when it is necessary. Therefore, total coverage is not possible in the sense that you suggested it was, unless you are going to say that this is the sort of coverage you want, which we recommend against, for many good reasons.

The next thing is that you can't say that all doctors are the same. A newly-qualified surgeon is not in exactly the same category as the senior professor of surgery. If you maintain that there should be no such thing as a junior demanding excess service, I do not know how you are going to stop him, nor if there isn't any difference between the senior professor and the newly-qualified surgeon, then at this point you are going to put your premium up enormously and you are going to swamp the senior surgeon and you are going to ruin general practice.

So those are the reasons for this statement. MR. COLEMAN: I do not think you have convinced me, but I will accept your answer.

MR. NAYLOR: Is extra-billing only done by specialists?

DR. THOMAS-ROBERTS: No, sir. Again, if you have a patient who demands an unreasonable amount of service, it would seem very reasonable to charge him for the service.



1 an average fee for an average service. If a doctor chooses to
2 belong to P.S.I. and he says, "I will accept this fee," that
3 is his business.

4 THE CHAIRMAN: It has been suggested here also
5 that charges are sometimes made in accordance with the indivi-
6 dual's ability to pay. Is that an accurate statement?

7 DR. ATKINSON: Our Association has looked at
8 this, Mr. Chairman, and some few months ago we recommended to
9 our membership - and it must be realized that we can only
10 recommend to our membership, that it is a voluntary Associa-
11 tion - that they adhere to the fee schedule in the usual
12 course of practice and use common sense.

13 We then asked the College, who are the disci-
14 plinary body in the province, to look at this particular
15 matter and they have a very definite statement about fees.
16 Now, if I might read it in part to you, this was passed in
17 April, 1963. (Reads).

18 We would submit this is a very reasonable
19 approach to professional fees.

20 MR. COULTER: Thank you, Mr. Chairman. On
21 this over-billing, which this apparently has something to do
22 with, the carriers will either pay you 90% or 100% of your
23 O.M.A. schedule of fees. I would have thought that the public
24 - and you correct me if I am wrong - I would have thought the
25 public would look upon this as the right and proper fee as



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1 100%. Either this fee is not set at the proper level or else
2 I do not see how you can collect on an over-billing. This
3 bothers me somewhat because I am positive that you could quite
4 easily misjudge a person's ability to pay.

5 DR. SAWYER: Mr. Chairman, I think there are
6 two or three things about a schedule of fees.

7 First of all, this is an Ontario Medical Asso-
8 ciation and the Province of Ontario is a very large province
9 and when you come down to setting an average across the
10 province, there are different circumstances in communities of
11 different sizes - the living costs are different, and so on.

12 What we have said to the members, in effect, is
13 this: that this schedule is a guide and we think that you
14 would be well advised to charge what is in this schedule,
15 unless you discuss the matter with your patient prior to the
16 billing.

17 Now, I think it is perfectly reasonable, if a
18 doctor is of some eminence and he is accustomed to charging a
19 fee that is higher than the schedule, and the patient comes to
20 him and he says, "Now, this is the fee that I charge for this
21 procedure," and the patient then has an election. They can
22 either come to that particular doctor or he can send them to
23 three or four of his confreres who charge a different fee.

24 I think so long as it is discussed with the
25 patient before the bill is rendered, that this is perfectly

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1 reasonable.

2 MR. COULTER: I would have to agree with you.

3 I have a very high regard for the doctor and for the community
4 doctor. But I would also have to agree that there might be
5 the odd one who would like to take advantage of a certain
6 situation.

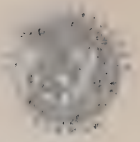
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8 that the profession have recognized their responsibility in
9 this area and we have established mediation committees, at the
10 local level, and the Executive of the Association acts as a
11 central mediation committee for the problems that can't be
12 answered locally, and where it is an out-and-out problem and
13 it seems to be beyond the jurisdiction of our Association, we
14 refer the matter to the College. And I think that this takes
15 care of this unusual situation that you refer to.

16 MR. COULTER: Thank you. Now, on the same page,
17 Section 19, regarding the Public Health Act - the repeal - I
18 am not too familiar with this particular Act. My understanding
19 is now that for the needy patients the fee for the Province of
20 Ontario, roughly -- do you get paid for your fees at \$1.25,
21 or something of this nature?

22 DR. ATKINSON: That is the people on the medical
23 welfare plan?

24 MR. COULTER: Yes.

25 DR. ATKINSON: We get \$1.25 per month.



MR. GOUTHER: I would have to agree with you.

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1 MR. COULTER: Is this the same Act that you are
2 paid by the profession - the Government?

3 DR. ATKINSON: No. The plan that you refer to
4 is a legal document, an agreement between the Government and
5 our Association and is not bound up in legislation.

6 THE CHAIRMAN: Is that not called an Act, the
7 Ontario Welfare Act?

8 DR. ATKINSON: There is an Ontario Welfare Act
9 but it does not set out the terms of the agreement. It puts
10 on government the obligation to provide the necessities of
11 life, including clothing, lodging, fuel and medical care -
12 medical services.

13 MR. COULTER: Why are you asking that this
14 responsibility be placed on each municipality? What is the
15 reason for this? I would like to know, for my own information.

16 DR. SAWYER: Mr. Chairman, if you look at what
17 you are trying to do in Bill 163, you are trying to get
18 insurance made available to all the people in this province and
19 you hope that the legislation that is finally brought in in
20 the Legislature will be such that people will insure themselves.
21 But at the present time there is really not much incentive for
22 a person who requires a partial subsidy to go out and buy
23 insurance, even if they are subsidized 50 or 60 or 70 per cent,
24 because they can walk into any doctor's office in the province
25 and get their medical services and if they are poor they won't



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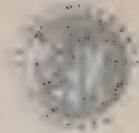
2 Now, what we are proposing here is that the
3 municipality be responsible, as it is to the Hospital Services
4 Commission Act, and it knows from its welfare officer the
5 persons that are needy - using that term broadly, and we are
6 suggesting that there be similar legislation passed that the
7 municipality will have an option to either see that these
8 people are insured or if they require medical services that
9 the municipality will pay for it because I am sure that if the
10 municipality thought the people could pay for it themselves,
11 they would say, "Well, now, you go and get insurance - we are
12 not going to look after you." And we say this is a method of
13 accomplishing what is set out in Bill 163.

14 MR. COULTER: In other words, Dr. Sawyer is
15 saying that the administration factor would be better localized
16 than in the municipality bill to the Provincial Government.

17 DR. SAWYER: They can make an arrangement. We
18 are not interested in how it is financed. We do not think the
19 municipality should pay it all. It might be shared with the
20 Provincial Government or with the Provincial and Federal Govern-
21 ment.

22 MR. COULTER: I would agree with this.

23 DR. GALLOWAY: I do not think you have quite
24 answered all that Mr. Coulter was asking. When he referred to
25 paragraph 89, he was talking of the operation of the Public



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answered all that Mr. Gowen was asking. When he referred to



1 Health Act and why it should be repealed.

2 DR. SAWYER: The Public Health Act, in Section
3 54, lays upon the municipality that it must enter into an
4 agreement with the medical officer of health in the municipi-
5 pality, or with some other physician in the municipality, or
6 some other physician in an adjoining municipality, to provide
7 out-of-hospital care for the needy people in the municipality.

8 Now, although it is mandatory the way the Act
9 is written, I do not know from my experience of any municipi-
4 10 pality which has an arrangement with the medical officer of
11 health to do this, or with any other physician in the municipi-
12 pality. Moreover, we do not think that this is a good way to
13 provide medical services to needy people, that the municipality
14 picks one doctor and to get their medical services they have to
15 go to that doctor. This does not work very well. So we think
16 this section should be repealed and in the new legislation
17 there should be a broad responsibility put on the municipality
18 such as they have done in the Hospital Services Commission Act.
19 This is what we are saying.

20 MR. COULTER: Thank you. On page VI (21):

21 "'No carrier, by a medical services insurance
22 contract, shall interfere with the right of
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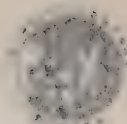
1 What happens to the welfare patient if he is
2 hospitalized? Does he have a choice of his own physician?

3 DR. ATKINSON: This will vary from one munici-
4 pality to another, depending on the medical community. In
5 some medical communities, and the one in which I practise,
6 the doctor who normally looks after this person in home or
7 office, follows him into the hospital and cares for him in
8 that situation. This may have a different application in
9 other areas. Perhaps Dr. Duggan would like to comment further.

10 DR. DUGGAN: To answer that, I can only say the
11 same thing, that being a family physician or a general practi-
12 tioner, I would object very strongly if I could not follow my
13 patient into the hospital. I have rendered the care to that
14 particular patient for some years. I think I know him very
15 well. I know his medical condition and in my municipality,
16 certainly, each physician follows his own patient into the
17 hospital.

18 MR. SIMON: The same is not true in Toronto,
19 though?

20 DR. DUGGAN: I was coming to that. I believe
21 that there are certain hospitals, by reason of their being
22 teaching centres, whereby the hospital is considered as a
23 closed hospital and only certain physicians are on the staff
24 of that hospital. Here again, my own personal feeling, and
25 this may not be the feeling of all the doctors in the province,



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of that hospital. Here again, my own personal feeling, and

this may not be the feeling of all the doctors in the province,



1 I think this is wrong. However, I do not want to get into an
2 argument on that particular subject, but this I would think
3 is probably only about four or five hospitals in the Province
4 of Ontario - though I am not sure of that figure.

5 MR. COULTER: What is bothering me here is that
6 - I do not know too much about the Toronto hospitals because I
7 am not a resident of Metropolitan Toronto - but in the outlying
8 districts, where it is my understanding, and I hope somebody
9 corrects me if I am wrong, that certain doctors have certain
10 working rights in certain hospitals -- is this true?

11 DR. ATKINSON: That is true. A doctor practi-
12 sing in a rural community would have to select the hospital
13 that would serve his practice the best. I think the restric-
14 tions are probably few and far between. Having practised in a
15 rural community, I had access to five hospitals and there is
16 no difficulty in sending patients -- as a matter of fact, some
17 patients would like me to have been associated with other
18 hospitals, but it is not possible in a rural area. You must
19 have some consideration for the economics of your own time
20 and ability to service more than a few hospitals.

21 Dr. Sawyer might be able to comment further.

22 DR. SAWYER: I think there may have been two
23 parts to your question, Mr. Coulter.

24 MR. COULTER: There is. There is another part
25 to follow.



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1 DR. SAWYER: The second part has to do with
2 practice privileges. Practice privileges apply in all
3 hospitals in the province and the Board of Governors of a
4 hospital sets the privileges of the doctors practising in
5 those hospitals, on the recommendation of the medical staff,
6 and this is done in the public interest because if you go to
7 a hospital and have to have your gall bladder out, you will
8 want to have some assurance that the doctor that is going to
9 take it out will be able to do a competent job. And this is
10 the reason that you have varying levels of privileges for
11 different doctors in each of the hospitals in the province.

12 MR. COULTER: Is there any problem in a rural
13 community where a doctor had rights in one hospital and not in
14 another that might be in the same community, where an indigent
15 patient could not get a bed in a hospital where he had the
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AG/rps 1 DR. BRUCE-LOCKHART: It's a problem sometimes,
2 sir, because of the reason Dr. Atkinson mentioned. In my
3 particular community there are three hospitals. It is extremely
4 difficult for a doctor to do routine visiting in three hospitals
5 in a day. It's uneconomical use of his time. So most
6 doctors elect to work in two hospitals out of the three. In
7 other areas they may elect to work at one of two hospitals,
8 if they are widely separated, and if a patient is indigent
9 and can only get into one of the hospitals, the doctor has to
10 decide whether in fairness to his other patients he can pursue
11 that patient into that hospital.

12 MR. COULTER: In other words he turns him over
13 to another physician in that hospital?

14 DR. BRUCE-LOCKHART: Again, whether patients
15 are indigent or otherwise, arriving without any doctor, there
16 is generally a staff setup of people on call that day who deal
17 with these people, whether indigent or not.

18 MR. COULTER: No. 22, on the same page, I would
19 just like it explained to me.

20 DR. ATKINSON: Mr. Chairman, this is a principle.
21 We believe that medical services insurance should be a separate
22 entity from any other insurance for health care, and that to
23 reflect the true cost of physicians' services, that this must
24 be carried out.

25 We recognize that at the present time, under the

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1 hospitalization program in the province, that certain physicians'
2 services are now paid through a hospitalization premium. We
3 recognize that to change this suddenly overnight would not
4 be in the best interests of all concerned. However, we
5 feel this is a principle that should be established at this
6 time.

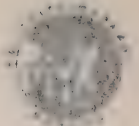
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8 detail from the questioning that has developed in the Enquiry
9 in other areas other than insuring medical services.

10 MR. SIMON: Just on this point, I would like to get
11 some further clarification. Is it meant that if a service
12 is rendered in a hospital under the Ontario Hospital Insurance
13 Act the patient doesn't receive the proper service as he
14 would under private doctor care, or what is the intent?

15 What do you mean by the word encroachment?

16 DR. SAWYER: I think we could explain it this
17 way, Mr. Chairman. Under the Hospital Services Insurance Act,
18 which is written to conform to Bill 320 of the Federal Act,
19 by regulation the Hospital Services Commission Act could be
20 modified so that they could include other services. It's
21 very broad.

22 Now, as an example, supposing the Hospital
23 Services Commission Act was broadened to include all out-patient
24 services, now, this would include radiology, clinical cardiology,
25 pathology, electrocardiogram, electroencephlogram, so these



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1 patients would be able to get this under their hospital insur-
2 ance if they went to a hospital, but not if they went to the
3 private practitioner's office, and there are all kinds of
4 radiologists and clinical pathologists practising privately.

5 Most of the internists in the province do
6 electrocardiograms. This would make it an insured service
7 if received at a specific location.

8 If you take Bill 163, on the other hand, the
9 services here are the services of a physician wherever rendered,
10 so that it wouldn't matter whether the services were received
11 at the out-patient department of a hospital, or at the doctor's
12 private office. They are insured wherever the patient likes
13 to get them.

14 MR. SIMON: So far as the patient is concerned,
15 he doesn't care where he gets his service, so long as he
16 gets it.

17 DR. SAWYER: Yes, if he can get it, but if
18 he lives 50 miles from a hospital, and there's a doctor in the
19 community who would give it to him, he has the option of
20 travelling 50 miles to get it under the insurance, or to pay
21 for it in the doctor's office.

22 MR. SIMON: But you aren't opposing the hospitals
23 who are now rendering this kind of service, because you are
24 using the word encroachment?

25 DR. SAWYER: Yes, encroachment means spread, that



patients would be able to get this under their hospital insurance if they went to a hospital, but not if they went to the private practitioner's office, and there are all kinds of radiologists and clinical pathologists practicing privately. Most of the internists in the province do electrocardiograms. This would make it an insured service if received at a specific location. If you take Bill 163, on the other hand, the services here are the services of a physician whenever rendered so that it wouldn't matter whether the services were received at the out-patient department of a hospital, or at the doctor's private office. They are insured wherever the patient likes to get them. MR. SIMON: So far as the patient is concerned, he doesn't care where he gets his service, so long as he gets it. DR. SAWYER: Yes, if he can get it, but if he lives 50 miles from a hospital, and there's a doctor in the community who would give it to him, he has the option of travelling 50 miles to get it under the insurance, or to pay for it in the doctor's office. MR. SIMON: But you aren't opposing the hospital who are now rendering this kind of service, because you are using the word endorsement? DR. SAWYER: Yes, endorsement means spread, and



1 it would spread into what is proposed in Bill 163.

2 MR. SIMON: Do I get it that it is duplication
3 in your opinion of that service?

4 DR. SAWYER: Not duplication. What we don't
5 want is to have insurance that is insured only if received
6 in specific places. We think it should be general, as under
7 Bill 163.

8 MISS REID: My question is sort of related
9 to what you have been discussing.

10 In page 1 of your summary and recommendations,
11 item three, you say that you agree with the basic principle
12 of Bill 163, and believe: "that the implementation of legis-
13 lation based on them will meet the requirements of Ontario
14 residents."

15 Well then, do you feel then that the medical
16 services, as proposed in this Bill, are sufficiently adequate
17 and comprehensive enough to make available to all residents
18 of Ontario satisfactory medical care?

19 DR. SAWYER: Well, I think, Mr. Chairman, you
20 are speaking here in the terms of Bill 163, which covers
21 physicians' services, and we're saying that the principles
22 enunciated in Bill 163, universal availability, non-cancellability,
23 and maximum premium that this will meet the needs of the
24 citizens of this Province for the insurance of physicians'
25 services.



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services.



1 This is what we're saying.

2 MISS REID: Then, may I ask you, do you feel
3 then that physicians' services are comprehensive enough to
4 give satisfactory medical care to the residents of Ontario,
5 physicians' services alone?

6 We have had delegations from quite a number of
7 groups, other groups in the medical team, such as optometrists,
8 psychologists, and so on, who wish to be included in the
9 services that are rendered to the residents of Ontario.

10 DR. ATKINSON: Mr. Chairman, I think that it
11 would be presumptuous on the part of our Association to assess
12 the care of people given by people other than a physician,
13 as defined in The Medical Act.

14 We're concerned here primarily with the prepay-
15 ment, or the insuring of the cost of medical services, which
16 we understand. There's nothing in our brief, and we would
17 want to have some consideration of the problem, if it was
18 decided to insure the services of other people in the health
19 care field.

20 We recognize that they are there, but beyond
21 that we could not be the judge of the services of others.

22 DR. HAMILTON: Mr. Chairman, the question is
23 not being answered. Miss Reid is asking, and the Commission
24 wants to know, do you after all represent the people who are
25 giving medical services to the residents of Ontario, and you



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DR. HAMILTON: Mr. Chairman, the question is

wants to know, do you often all represent the people who are
giving medical services to the residents of Ontario, and you



1 have been asked, and you have stated here, that the legislation
2 will meet the requirements of the Ontario residents.

3 You are being asked what really are the
4 requirements of the residents of Ontario for medical services?
5 What do you understand by it? What do you mean by the state-
6 ment in No. 3?

7 DR. SAWYER: Mr. Chairman, if I interpret
8 the question correctly, we agree that the benefits as outlined
9 do adequately provide for medical care, quite separate from
10 health care.

11 There are other groups who may interpret it to
12 you ---

13 DR. HAMILTON: We're not asking about other
14 groups, Dr. Atkinson.

15 DR. ATKINSON: Talking about medical services
16 per se, as you and I understand it, Dr. Hamilton, are outlined
2 17 in the schedules that are part of the Bill, the benefits of
18 the Act to pay for the necessary medical services of a
19 physician wherever required.

20 There are certain exceptions, and we can deal
21 with the exceptions as specific items.

22 DR. BRUCE-LOCKHART: Mr. Chairman, I think we
23 are in danger of crossing swords in semantics. In our
24 interpretation of the Act we have interpreted it as physicians'
25 services ---



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DR. BRUCE-BLOCKHART: Mr. Chairman, I think we

are in danger of oversteering towards the anomalous. In our

interpretation of the Act we have interpreted it as physicians



1 THE CHAIRMAN: This is defined in the Act.

2 DR. ATKINSON: If you wanted to ask, and I
3 was it quite sure, for instance one should include some
4 insurance for physiotherapy, optometrists, and any other
5 groups that are licensed in one way or another in this Province,
6 then there's a very broad field, and we would have to take it
7 under advisement, and go into it in detail.

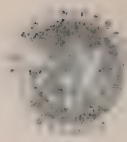
8 MISS REID: What I was really interested in
9 was whether you felt that medical services should be restricted
10 to physicians' services, as they seem to be in this Bill?

11 DR. ATKINSON: Mr. Chairman, I think again it's
12 a matter of definition, and I think the definition of physician
13 and surgeon is clearly outlined in this Act, and also clearly
14 outlined in The Medical Act, and my understanding of The Medical
15 Act is that medical services, as defined, can only be
16 rendered by physicians or surgeons as defined in that Act.

17 MR. SIMON: Surely you can tell us if nursing
18 services are included?

19 DR. ATKINSON: Nursing services aren't medical
20 services. If the Commission, or the Enquiry, wish to have
21 an opinion as to the insuring of para-medical services, then
22 again this would have to be outlined, nursing services and
23 physiotherapy -- I presume you wish us to take that under
24 advisement?

25 MR. WHITNEY: What Miss Reid is inviting you to



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account?

MR. WHITNEY: What Miss Reid is inviting you to



1 do is to let your hair down a bit. I think you are feeling
2 yourself unduly constrained to Bill 163, and what she's
3 asking now, and you've done it a bit in your own brief -- in
4 one place you mention drugs -- she wants you to say whether
5 you feel that the Bill is really covering the health require-
6 ments of Ontario, and do you have any strong feelings about
7 not necessarily the inclusion now, but including all the
8 health services, and don't think it's presumptuous on your
9 part, because the doctors do refer people to other health
10 services, and I think Miss Reid wants you to tell us about
11 what you think of the limitations of the Act.

12 Is that right Miss Reid?

13 MISS REID: Yes, I want to know what your
14 opinion is as regards the adequacy?

15 You state that you think this Bill will meet
16 the requirements of the Ontario residents. Do you think those
17 requirements are met strictly through the provision of
18 physicians' services?

19 THE CHAIRMAN: Possibly the illustration that
20 you used there was an unfortunate one in one way. I believe
21 what you are aiming at here is, do you think that as a medical
22 health Bill to some extent does this Bill go far enough?

23 As Mr. Whitney says, you have suggested that
24 sometime in the future drugs might be available. Certainly,
25 as Chairman, I do not wish to see a discussion entered into here

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1 as to whether you consider that a chiropractor or optometrist
2 should be included in this, and those two I believe were
3 named.

4 But we don't want to get into that. They
5 presented their case, and they weren't critical of the medical
6 people.

7 DR. ATKINSON: I think our viewpoint is this,
8 that in terms of the Bill as it is tabled in the legislature,
9 it refers specifically to the personal services of a physician.

10 Now, when you consider the, what we would
11 term para-medical services, and we would include drugs and
12 such things as that, we have stated our position, that we
13 feel that they should not be insured as part of medical
14 services.

15 Again it gets into the discussion we had
16 previously, the inclusion of medical services in hospitalization.
17 The same argument applies. This did not mean, however, that
18 we do not feel that legislation and the insuring mechanism
19 can't be developed. We have not turned our heads against this,
20 and again we would have to give it due consideration.

21 We feel this would involve discussion of the
22 carriers. P.S.I., through standard health benefits, provide
23 coverage in this area, and the carriers under C.H.I.A., under
24 the major medical plans, also provide it, but I think it is
25 a separate question, and we would want to take it under advise-



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1 ment.

2 I recognize the two areas, but I would suggest
3 to the Committee that between the two very distinct areas that
4 we delineate now, there is a grey area, which we would not
5 wish to delineate, but we would point out to you that between
6 what is strictly para-medical, and what is health care in other
7 fields recognized in legislation, there is an area that would
8 require careful scrutiny and study.

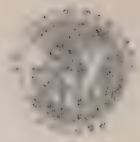
9 MISS REID: On page 38, the matter of health
10 examinations. Would you comment further on that, or elaborate
11 on what you said?

12 In paragraph 135 you say:

13 "Rarely is disease discovered in a patient who
14 "has no signs or symptoms."

15 And this eventually leads up to your recommend-
16 ation that the exception by reworded in health examinations.

17 DR. ATKINSON: I think, Mr. Chairman, that this
18 is an area that is open to considerable feeling. There have
19 been studies made of the use of so-called routine health
20 examinations, and I use the word so-called advisably, because
21 when you delve into what is being done in this field, it is
22 not an examination by a physician in his office, but it is
23 carried out in a rather complex mechanism, and the end results,
24 in the opinion of a number of people, do not justify this great
25 expense for the actual disease found, and our statement rarely



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1 is a disease discovered in patients who have no signs or
2 symptoms, is borne out. We feel that the patient who comes
3 to the doctor's office and says: "Doctor, I want a checkup.
4 I haven't been in for some time". In most cases he comes
5 because he has a symptom. Now, it may be a symptom because
6 of fear of cancer, or heart disease, but this is a symptom.
7 He may have a little tightness in his chest after cutting the
8 lawn. He is afraid to recognize this himself, but hides
9 behind the general statement: "I want a checkup".

10 DR. DUGGAN: I speak as a family doctor, or
11 general practitioner, and I think that of the majority of
12 families that I look after each year, I would see perhaps
13 on the average the mother and father and the three children,
14 if they have that many, or more, I would see them once or
15 twice a year, and sometimes in the case of the children more
16 often, depending on their age, and the diseases they are
17 susceptible to.

18 I think I know those patients very well, and
19 in that particular instance an actual health examination to me
20 is no value to the patient at all, other than to re-assure
21 them, because the times I see them during the year, I think
22 I pick up anything that they might have, and perhaps aren't
23 aware of.

24 There are many cases, of course, I know, where
25 the benefits and advantages or disadvantages of this particular

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1 annual health examination, but certainly it has been my
2 experience where a patient comes to me who has no complaints,
3 that after very careful examination I find no evidence of
4 disease.

3 5 DR. BRUCE-LOCKHART: There's another facet
6 to this problem, Mr. Chairman, which causes us some concern,
7 and that is that there seems to be a general shortage of
8 medical manpower, and that I don't think there's any doubt
9 really that routine preventive medicine, if carried out on
10 a wide scale, has some benefit, but if you are going to do
11 an annual checkup on every patient in Ontario, there won't
12 be enough doctors to look after anybody else.

13 So there's another factor that basically at
14 the present time we feel, and we have given a lot of thought
15 to this problem, that the available manpower are much better
16 used concentrating on the early symptoms of disease than
17 trying to offer something which we really couldn't deliver.

18 There's one other small point which I think
19 is more cogent than people realize, and that is certain of
20 the dangers about an annual checkup, particularly if you are
21 being rushed, and one of our problems at this time is that
22 this pressure tends to build up, is that a patient is examined,
23 given a clean bill, and three months later develops a minor
24 symptom, which if he hadn't got a clean bill of health three
25 months earlier, he would have gone to the doctor with, and now



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1 he doesn't so there's another aspect again.

2 MISS REID: Then, on page 43, item 154(c),
3 you are recommending a new sub-Section (e) to the exceptions:

4 "ANY OTHER SIMILAR EXAMINATIONS REQUIRED

5 "OTHER THAN FOR THE HEALTH OF THE PERSON

6 "COVERED."

7 DR. ATKINSON: We put this in, Mr. Chairman,
8 for the sort of completeness, but the terminology indeed
9 is referring to the same types of situations that you have
10 enumerated in a, b, c, and d, that is that it's an examination
11 requested by some other party, be it employer. We just put
12 it in to get it a general clause along the same lines.

13 MISS REID: Then, regarding
14 the Advisory Committee, on page 56, could you give us a little
15 more explanation of what you mean by alternates?

16 DR. ATKINSON: Mr. Chairman, first of all we
17 have established the Advisory Committee, and in my introductory
18 remarks I indicated that this was a new idea, and it was not
19 just within our own Association, and it's our opinion that
20 the proper functioning of this Advisory Committee will only
21 be successful in that there be full membership at any meeting.

22 I think that this is understandable, because
23 in our working with committees, we find that a committee that
24 is comprised of approximately nine, or of that order, functions
25 extremely well. This is a committee that will give you a



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1 good spread of opinion, and yet not be a weighty committee of,
2 say of the order of eighteen or twenty.

3 Therefore, to make sure that there is this
4 adequate representation, and the three groups that are outlined
5 here, the consumer, the public, the insuring agencies, and
6 the medical profession are represented, there should be a
7 mechanism for providing alternates.

8 Now, we feel that the Province spelled this
9 out in some detail just to ensure that the alternate can be
10 made available at the convenience of the situation, if a
11 member became sick he wouldn't have to go back to his parent
12 body to have an alternate appointed, and this would be an
13 acceptable procedure to all concerned.

14 DR. BRUCE-LOCKHART: I think there would be
15 difficulty. By "that person", it means "body". It means
16 therefore by the same people who appointed the representatives.

17 We're using "person" in its legal sense.

18 DR. SAWYER: It may be, Mr. Chairman, that
19 in our Association we have always a dozen committees going,
20 and we find it hard to get attendance..

21 MISS REID: In this representation on the
22 Advisory Committee of the providers of medical service, what
23 percentage of medical practitioners are members of the Medical
24 Association?

25 DR. SAWYER: The last figure we had was 8,100



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1 in the College, and at that time our membership was 7,200, so
2 we had some 85%.

3 MISS REID: This would presuppose that the
4 providers of medical services would be licensed physicians?

5 DR. ATKINSON: Yes.

6 DR. HAMILTON: I would like to ask Dr. Atkinson
7 again coming back to page I, paragraph III:

8 "We agree with the basic principles of Bill 163,
9 "and believe that the implementation of legis-
10 "lation based on them will meet the requirements
11 "of Ontario residents."

12 Now, Dr. Bruce-Lockhart said there's a shortage
13 of physicians in Ontario. Are there then residents in Ontario who
14 aren't receiving medical services?

15 DR. ATKINSON: Mr. Chairman, this is a state-
16 ment that has been made on several occasions over the past
17 number of years, and we have yet to receive ample documentation
18 that such is the case.

19 We recognize that at times there are circum-
20 stances which seem unusual and unreasonable at the time, but
21 this is something that we just haven't had documented to
22 our satisfaction.



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DR. HAMILTON: I would like to ask Dr. Atkinson

again coming back to page 1, paragraph III:

"We agree with the basic principles of Bill 103,

"and believe that the implementation of legis-

"lation based on them will meet the requirements

"of Ontario residents."

Now, Dr. Bruce-Lockhart said there's a shortage

of physicians in Ontario. Are there then residents in Ontario who

aren't receiving medical services?

DR. ATKINSON: Mr. Chairman, there's a state-

ment that has been made on several occasions over the years

number of years, and we have yet to receive ample documentation

We recognize that at times there are circum-

stances which seem unusual and unreasonable at the time, but

this is something that we just haven't had documented to

THE PRESIDENT:



MR/dpw 1 DR. HAMILTON: You don't know whether there is
2 or is not a sufficient number of physicians in Ontario?
3 DR. SAWYER: I wonder if I might just answer
4 that question in this way: that being in the office of our
5 Association, I am in contact with doctors from all over this
6 province, as you can appreciate, and I can say this, that in
7 the last year or two we have had extreme difficulty in finding
8 general practitioners for many areas in this province. Doctors
9 write in or 'phone in, "Would you get somebody to come and
10 help me? I am alone. I am working long hours. I cannot get
11 away for a vacation. I cannot get away for post-graduate
12 study."
13 Now, this seems to be an increasing situation
14 over the last year or two.
15 DR. HAMILTON: So that there are some areas in
16 which there is not an adequate number of physicians?
17 DR. SAWYER: Yes. I would say that is so.
18 DR. ATKINSON: I think, Mr. Chairman, my
19 answer was that we have no knowledge of people being deprived
20 of medical care because of this imbalance in the medical
21 population.
22 DR. HAMILTON: Is anyone being deprived of
23 medical care because they cannot pay for it?
24 DR. ATKINSON: No, sir.
25 DR. HAMILTON: Thank you.



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answer was that we have no knowledge of people being deprived

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medical care because they cannot pay for it?

DR. ATKINSON: No, sir.

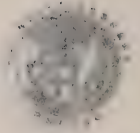
DR. HAMILTON: Thank you.



1 MR. CASWELL: Mr. Chairman, may I just ask a
2 question here? Is there a shortage of doctors or a poor
3 distribution of doctors? Do medical men tend to live and work
4 in the larger municipalities with better hospital services?

5 DR. BRUCE-LOCKHART: I think these two things
6 tie up. When you are generally a little short, and everyone
7 is working under pressure, the doctor has a very wide selection
8 of where he can go and survive. If you have a slight surplus
9 of doctors, on the other hand, then you tend to find people
10 will move to the areas without doctors, so I think there is
11 both. I think there is some bad distribution but there are no
12 over-doctored areas.

13 MR. CASWELL: I would like to ask a further
14 question. In your submission to the Royal Commission you
15 stated that since the inception of the Ontario Hospital
16 Services Commission you have a very strong feeling of more and
17 more government interference, and as a result of this you have
18 had a feeling of more and more government interference in the
19 medical profession, so much so in that statement you said that
20 young people are suggesting they are not interested in joining
21 the medical profession because of the fear of government inter-
22 ference. Very honestly, as a layman who travels a great deal,
23 this came as quite a surprise to me to read. I have never
24 before heard any expression from young people, or the medical
25 doctors that I know, that there was any sign of government



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this came as quite a surprise to me to read. I have never

before heard any expression from young people, or the medical

doctors that I know, that there was any sign of government



1 interference in the medical profession in Ontario.

2 I would feel that if this was so, if there is
3 some government interference or suggestion of it, perhaps
4 this is something that this committee should be knowledgeable
5 of and concerned with. We certainly would want to encourage
6 people to enter the profession, not discourage them. It
7 sounded very strong in your submission to be told that young
8 people are staying away from entering this profession because
9 they are afraid of government interference and suggested that
10 this is so in the Province of Ontario.

11 DR. BRUCE-LOCKHART: Mr. Chairman, I think you
12 have to remember that that was at the time they ~~were~~ sitting
13 in a Royal Commission. It was also very close to the Saskat-
14 chewan situation and Bill 163 was not on the floor or even
15 being talked about and we were talking about, and also the
16 questions we were being asked in front of that Commission and
17 had been asked right across the Dominion was very much along
18 the lines of, "What do you think about the Government providing
19 medical care?" so that this was the text of these discussions.

20 We were asked a lot of questions in this parti-
21 cular area and we did come up very strongly that we did not
22 think, the way the total government scheme was, it was in the
23 best interest of everybody, and we said so.

24 MR. CASWELL: I think we would like, though -
25 it suggested to me that the Ontario doctors were simply buying



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best interest of everybody, and we said so.

MR. GARDNER: I think we would like, though -

it suggested to me that the Ontario doctors were simply buying



1 themselves insurance at that hearing.

2 DR. BRUCE-LOCKHART: I don't think that is quite
3 true. I think we were trying to state our viewpoint and make
4 it very clear, and I think we succeeded. On the other hand,
5 we were concerned about one thing, and that was, it seemed to
6 be quite an impression, it was hard to get cold facts on it,
7 that very few doctors' sons were coming into medicine and one
8 of the reasons seemed to be the doctors were afraid of the
9 future, afraid of the profession of medicine; we didn't think
10 this was a very healthy state.

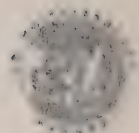
11 MR. SIMON: For the record, there are 40 doctors
12 more in Saskatchewan now than there were before the medical
13 insurance plan was put into effect.

14 MR. CASWELL: I don't agree, Mr. Chairman, with
15 government interference in the medical profession.

16 MR. SIMON: I am making a statement for the
17 record.

18 MR. CASWELL: I wondered if there was any sign
19 of this; I think this Enquiry should know.

20 MR. SIMON: I am interested in a statement
21 made before to a question by Dr. Hamilton that no one in the
22 province is denied medical service. I don't know how you
23 doctors can say that. You can probably say no one is denied
24 medical service when they go to the doctor, but there are
25 thousands of people that do not go to a doctor because they



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medical service when they go to the doctor, but there are

thousands of people that do not go to a doctor because they



1 cannot afford to pay for it, and stay home and develop further
2 sickness.

3 DR. ATKINSON: Mr. Chairman, the statement that
4 has been made, we have asked on previous occasions for it to
5 be documented and it is very difficult, and that is one
6 reason why we supported the principle outlined in this present
7 legislation, because this would overcome that problem, wherever
8 it existed, if it does exist, and again we have not been able
9 to have this documented for our perusal and action.

10 I would ask Dr. Melvin to speak to the question
11 of medical education and recruitment.

12 DR. MELVIN: There is one question under the
13 Ontario Hospital Services Commission and this is influence
14 on the medical practice. It definitely has one. I would not
15 imply that any agent of theirs would come down and tell me
16 how to fix a broken leg or how I am to treat a patient, but
17 the fact remains that by controlling the purse strings they
18 control what goes on. If they will only hire so many people
19 to work in an operating room, that closes down the operating
20 room. They control the amount of surgery that is going to go
21 on in the hospital on a given date. It is this blunt level
22 of control that we are concerned with. This very definitely
23 is happening. The fact remains the amount of surgery I can
24 do is controlled in the Ontario Hospital Services Commission
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1 in the operating room. This is a definite factor, as far as I
2 am concerned. This is a form of pressure that is brought to
3 bear.

4 The other question of education of doctors
5 concerns all aspects of education. It concerns, for example,
6 to discover why a higher percentage of people coming out of
7 high school were not going on in medicine. That is in our
8 brief, the exposition of it, and this ties in with the question
9 of the doctor population. If one only has one doctor to serve
10 a community at the cost of working 18 or 20 hours a day, every-
11 body being seen, this is to the detriment of the doctor's
12 health and certainly it does not impress his children. I
13 have heard the statement said in our own family, "I am not
14 going to live like you do. I don't have to. Nobody else's
15 father behaves the way you do." This is not the only fact,
16 but this is a fact. This comes down to the under and over-
17 doctored; you follow me?

18 MR. CASWELL: This sounds very familiar.

19 DR. MELVIN: If there is only one doctor
20 serving the community, working 18 hours a day, seven days a
21 week, only one doctor, that is still an under-doctored community.
22 They can support two doctors; this would give both doctors a
23 reasonable existence. Do I make my point about the shortage
24 of doctors? This is being bridged by this stretching of the
25 individual general practitioner out of human resemblance.

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1 the length of time it takes for the young person to go through
2 university and the expensive cost of education.

3 DR. MELVIN: Yes, sir; and in fairness to the
4 Association, I have had high school principals, who I
5 approached about this, and they think some of their students
6 are worried about government interference. If they are going
7 to be civil servants, well, why spend six years in medicine
8 to be one? Why not take a pass Arts and get it over with?

9 DR. SAWYER: I just want to make two comments.
10 Before we wrote that in the brief, Mr. Caswell, we did go to
11 the trouble of writing to a number of high schools in the
12 province - we got the permission of the principal - to ask the
13 students in Grade 12 or 13, I have forgotten which, to fill in
14 this questionnaire as to what they were going to do, and it
2 15 was on the basis of those replies that we made that statement
16 in there and as Dr. Bruce-Lockhart said, of course, it was
17 right at the time of this Saskatchewan controversy.

18 I would like to make a comment about something
19 that Mr. Simon said. This question whether people stay at
20 home and do not seek medical service: now this is a statement
21 that is made and it was made in a letter to the editor in one
22 of the Toronto papers, and I took the trouble to write to the
23 woman who made this statement and I said, "Now, as an Associa-
24 tion, we are interested in this, and we would like the names
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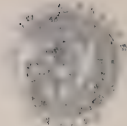
2 MR. SIMON: For your information, there are
3 associations that appeared before this Commission, the Social
4 Workers that appeared before this Commission have told us
5 exactly these things, from their own experience, and they know
6 of patients who do not go to doctors because they cannot afford
7 it. It is not my statement.

8 THE CHAIRMAN: I think we are getting a little
9 off the line. We interrupted you, Dr. Hamilton. Dr. Hamilton
10 had the floor. I would like to pass it back to him.

11 DR. HAMILTON: Thank you. On page 4, summary
12 and recommendations, paragraph 13, it is said that government
13 insure the benefits of Schedule A on the basis of first-dollar
14 coverage. Government make an arrangement with the Ontario
15 Medical Association for the insurance of this group. Would
16 you please tell me why? Why does the Ontario Medical Associa-
17 tion wish to enter the insurance field?

18 DR. ATKINSON: Mr. Chairman, I don't think that
19 the Ontario medical welfare plan could be termed "insurance."
20 This is the result of an agreement and this plan is documented
21 in the blue pages, in Appendix 1 of our submission. This is
22 an arrangement between government and the profession to
23 administer a fund to assist in the paying of medical services
24 for a very specific delineated group.

25 DR. HAMILTON: Under Section A(1) you say the



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THE CHAIRMAN: I think we are getting a little off the line. The question is, would you like to pass it back to him.

DR. HAMILTON: Thank you. On page 4, summary and recommendations, paragraph 13, it is said that government insure the benefits of Schedule A on the basis of first-dollar coverage. Government make an arrangement with the Ontario Medical Association for the insurance of this group. Would you please tell me why? Why does the Ontario Medical Association wish to enter the insurance field?

DR. ATKINSON: Mr. Chairman, I don't think that the Ontario medical welfare plan could be termed "insurance." This is the result of an agreement and this plan is documented in the blue pages, in appendix I of our submission. This is an arrangement between government and the profession to administer a fund to assist in the paying of medical services for a very specific delineated group.

DR. HAMILTON: Under Section A(1) you say the



1 Government insure the benefits of Schedule A on a basis of
2 first-dollar coverage. Would this be the same as insurance
3 under Schedule A for the individual who purchases it? He
4 would get the same benefits?

5 DR. BRUCE-LOCKHART: Yes. He would get exactly
6 the same benefits.

7 DR. HAMILTON: What is the difference? Why
8 does the Ontario Medical Association wish to do this?

9 DR. BRUCE-LOCKHART: There are many factors to
10 be considered, sir, and we looked at those in very great length.
11 The first is this group of people are all on welfare and have
12 to apply for help in other directions so that for any
13 machinery that can be set up it is quite important for this
14 group of people that there should be simple machinery, they
15 can easily understand and presently this has worked very well.
16 In other words, it has worked since 1935, has been developed
17 and refined and has proved very satisfactory both to the
18 welfare people and to the people who are being looked after.
19 We think it would be very complicated and cumbersome for our
20 Welfare Department to have to contact a multiple carrier and
21 persuade these people to choose a carrier.

22 We feel that we should make sure that the
23 patient gets his identification quickly; that the doctor
24 knows quickly, because these people occur very suddenly, and
25 there is continuity of coverage. This might prove a problem



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1 to multiple carriers. It would be, I think, a considerable
2 headache to all the carriers to deal with a group of these
3 people and it would have to be funded separately because the
4 Minister told us originally that this would obviously have to
5 be dealt with on a no-profit, no-loss basis. For all these
6 reasons it seems simpler to use the mechanism presently
7 existing.

8 Now, if you are going to buy insurance contracts
9 with these people, you come up against another problem. There
10 are going to be all sorts of risks, all sorts of different
11 risks and this would be much more complicated for government
12 to budget. This seems another disadvantage of this particular
13 group. Then you get into the same problems - also the fact
14 this is a high-cost group.

15 DR. HAMILTON: Then would the fees billed to
16 the doctor be different for this group?

17 DR. BRUCE-LOCKHART: This would be a matter for
18 the Government to make up its mind on what it wants to do about
19 it. We are suggesting this is a simple administrative
20 machinery that has worked very well. It would be a headache
21 for carriers and this should be responsibility accepted by
22 government if it is basically a government plan. I think it
23 would be much simpler for them to deal with one carrier. If
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25 the tried mechanism than to start evolving another one. I



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1 think these are the reasons.

2 DR. SAWYER: I think there are two or three
3 things that should be said about the medical welfare plan and
4 the people on it. First of all, if you are going to insure
5 these people, you would have to make up your mind whether you
6 are going through multiple carriers or single carriers. I
7 have the figures here for September, 1963, which is the last
8 month that has been put on my desk. At that time there were
9 210,212 people insured. Of that number, 79,313 were on
10 general welfare assistance. Now, this means that you have to
11 deal with all the municipalities in this province in that
12 month to get payment for these 79,313 people and to do this
13 through multiple carriers I think would be very difficult.

14 I agree that you can do it through one carrier,
15 be it the welfare plan or P.S.I. or any other carrier. If you
16 look at one carrier, then you should look at certain other
17 figures. Of that 210,000-odd, there are 55,861 over the age
18 of 70 and 20,129 between the ages of 65 and 70, so that of
19 210,000, 76,000 are over the age of 65.

20 Now, if you compare 76,000 to 210,000 and
21 realize that the general percentage of people are over the
22 age of 65 in the general population, you will see that you
23 have here a very high-cost group of people and if you add to
24 that 13,775 who are totally disabled, this again brings them
25 into a very high-cost group of people.



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1 Now, if you insure under one carrier, and the
2 Government decided it would pay the going premium, which in
3 this case would be a high premium, and if it insured under
4 certain carriers, I assume that this 76,000, plus the 13,000,
5 would be all insured at the maximum premium because they are
6 very high-cost people.

7 Now, what would happen: all the loss engendered
8 in those seventy-six, plus 13,000 people, would then be spread
9 back across all the other people in the province who had
10 bought insurance.

11 In other words, the Government would not be
12 picking up the cost of insuring the people for which it had
13 accepted responsibility. I do not think it would be the inten-
14 tion of government to slough off on the other people in the
15 province who had insurance the true cost of insuring this
16 group of people.

17 THE CHAIRMAN: I think you said it is the Govern-
18 ment that is going to take the loss?

19 DR. SAWYER: No. The people of the province
20 would be taking the loss. They would be carrying part of the
21 actual cost to insure this high-cost group of people.

22 THE CHAIRMAN: This would be very little
23 different, actually, than what is going on at the present time.
24 Primarily the indigents are under Schedule C.

25 DR. SAWYER: But now, you see, it is shared by



Now, if you insure under one carrier, and the Government decided it would pay the going premium, which in this case would be a high premium, and if it insured under certain carriers, I assume that that \$6,000, plus the \$2,000, would be all insured at the maximum premium because they are very high-cost people.

Now, what would happen: all the loss encountered in those seventy-six, plus 13,000 people, would then be spread back across all the other people in the province who had bought insurance.

In other words, the Government would not be picking up the cost of insuring the people for which it had accepted responsibility. I do not think it would be the intention of government to shift it on the other people in the province who had insurance, and the cost of insuring that group of people.

THE CHAIRMAN: I think you said it is the Government that is going to pay the loss.
MR. SAWYER: The people of the province would be taking the loss. They would be carrying part of the actual cost to insure this high-cost group of people.
THE CHAIRMAN: That would be very little.

difference, actually, than what is going on at the present time. Primarily the incidents are under Schedule C.
DR. SAWYER: But now, you see, it is shared by



1 all the people of the province whether they have insurance or
2 not. This comes out of general consolidated revenue and we
3 think this is a proper way it should be done. It could be
4 done through a single carrier if you take this group and take
5 a premium that is appropriate.

6 THE CHAIRMAN: What I mean is what you are
7 recommending here is very little different to what is going on
8 at the present time?

9 DR. SAWYER: Except the benefits should be
10 enlarged.

11 DR. HAMILTON: Full fees will be paid?

12 DR. ATKINSON: The policy of our Association is
13 we do not accept a pro-rated fee, with the exception of the
14 doctor-sponsored plans and this is the policy developed in
15 application to Bill 163. Now, if government came to the
16 Association, and again we are entering into an agreement,
17 this would be a matter of discussion and negotiation and our
18 Council, the governing body of the Association would have to
3 19 say what the profession would do in this regard. The Executive
20 or the Board would not be able to bind the profession.

21 MR. CASWELL: Mr. Chairman, may I interrupt for
22 a moment and ask for clarification on that? My understanding
23 was that government pays \$1.25 per welfare person, not patient,
24 but person, and this goes into a fund from which the doctors
25 are paid for their services and the last figures that were



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all the people of the province whether they have insurance or not. This comes out of general consolidated revenue and we think this is a proper way it should be done. It could be done through a single carrier if you take this group and take a premium that is appropriate.

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MR. SAWYER: The policy of our Association is

we do not accept a guaranteed fee, with the exception of the

doctor-sponsored plans and that is the policy developed in

application to Bill 103. Now the government came to the

Association, and said we are seeking info on agreement,

this would be a matter of consultation and negotiation and our

Council, the governing body of our Association would have to

say what the professional would do in this regard. The Executive

or the Board would not be able to bind the profession.

MR. SAWYER: Now, Chairman, may I inquire for

a moment and ask for clarification on that? My understanding

was that government says that the welfare person, not patients,

but person, and this goes into a fund from which the doctors

are paid for their services and the last figures that were



1 presented from this fund, the doctors were paid approximately
2 78% of their normal fee; am I wrong there?

3 DR. SAWYER: It varies, Mr. Chairman, depending
4 on the amount of service required and the amount of money in
5 the kitty.

6 MR. CASWELL: This is what I am suggesting. In
7 other words, you were accepting a pro-rated fee? You weren't
8 getting 100% for your fee?

9 DR. SAWYER: It is a little difficult to get
10 100% of your fee when you are dealing with government.

11 MR. CASWELL: I appreciate that and this is why
12 I would like to see it undisturbed.

13 THE CHAIRMAN: They are suggesting here that it
14 be negotiated. It is now negotiated, as I understand it, to
15 some extent. It started out at 25 cents and this increase to
16 \$1.25 has been a negotiated increase, not just the Government
17 saying, "We are going to increase this."

18 DR. ATKINSON: We had discussions with the
19 Minister.

20 THE CHAIRMAN: Probably "negotiated" is a bad
21 word. You had discussions.

22 MR. SIMON: Collective bargaining.

23 THE CHAIRMAN: We are getting again out of line.
24 Dr. Hamilton, do you wish to continue?

25 DR. HAMILTON: On page 4, Section 11, you say the



presented from this fund, the doctors were paid approximately

78% of their normal fees, are I wrong there?

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DR. HAMILTON: On page 4, Section 11, you say the



1 amounts of benefits payable under standard contracts be set out
2 more specifically in Section 17. I wasn't quite clear what
3 you mean by amount of benefits payable. Is that not the
4 schedule of fees?

5 DR. SAWYER: If you look in the appropriate
6 section, which I think, from memory, is Section 17, the
7 wording is computed on the basis of, and it was our feeling
8 that this was not setting out very specifically the benefits
9 that would be paid, because it is computed on the basis of,
10 it might be any percentage that the carrier elected to pay.

11 DR. HAMILTON: Thank you. Then on page 5,
12 where you say that all subsidized medical services insurance
13 contracts bear some mark or code which will make it apparent
14 to the doctor that the patient is in receipt of subsidy, I
15 think probably the question was answered when asked by Miss
16 Reid. There was only one question I wished to ask for informa-
17 tion. Extra-billing, it was my understanding some time ago,
18 used to be done by doctors when the patient could well afford
19 to pay something a little more than the standard fee, and
20 such patients were charged this because the doctor had many
21 patients who did not pay a standard fee or who did not pay at
22 all. Is this a misconception on my part that this was part of
23 the origination?

24 DR. SAWYER: I think we should get the terms
25 straight, Mr. Chairman. Extra-billing, in the general use of



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DR. SAWYER: I think we should get the terms
straight, Mr. Chairman. Extra-billing, in the general use of



1 the word, is the billing between the general practitioner's
2 schedule and the specialist's schedule.

3 DR. HAMILTON: That is not what I mean. I mean
4 the higher fee might be charged.

5 DR. SAWYER: Yes. I think this is right.

6 DR. HAMILTON: Fees higher than listed in the
7 schedule of fees?

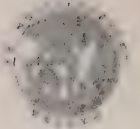
8 DR. SAWYER: Yes. I think over the years, if
9 you want to go back into history, I think the general attitude
10 of the profession was that in order to look after the people
11 who had no money, they charged the people that had a lot of
12 money a higher fee than the ordinary going fee. I think this
13 is quite true.

14 DR. ATKINSON: I think, Mr. Chairman, this
15 situation still exists in certain parts of North America. I
16 am thinking of certain large clinics in the south.

17 DR. HAMILTON: You don't think it exists in
18 Ontario?

19 DR. ATKINSON: I think it may exist, to some
20 extent. I don't think it exists to the extent it is a
21 problem.

22 DR. HAMILTON: I don't think of it as a
23 problem at all. I was merely asking if it was not a perfectly
24 justifiable and honest procedure when an individual is giving
25 much of his time, a doctor, for which he has received no



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1 recompense at all; some people who had more money were able to
2 pay a little more, and paid a little more, and did not object
3 to so doing.

4 DR. ATKINSON: We would have to accept that
5 this is a legitimate procedure in that particular practice.
6 It fitted in with the principles of billing as laid down by
7 the College and this spells it out quite definitely, I think.

8 DR. HAMILTON: Then on page 6, paragraph 22,
9 I still am not quite clear what you mean by encroachment by
10 the Hospital Services Insurance Act. This is encroachment of
11 what?

12 DR. ATKINSON: Mr. Chairman, our Association,
13 some years ago, took a look at the provisions on out-patient
14 services by the hospital and we made a survey of the province
15 and found that many doctors at that time had facilities for
16 providing electrocardiographs, certain physiotherapy provisions.
17 There are a number of doctors in the province who are in
18 private practice in radiology who have offices established
19 apart from the hospital communities.

20 We feel that nothing should interfere with what
21 we think is the normal part of the practice of medicine.

22 Now where you would get this, Mr. Chairman, is
23 where the Hospital Services Commission would extend these
24 facilities to provide out-patient diagnostic and treatment
25 services so that if a patient required an electrocardiograph,



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1 and this could be paid for under the O.H.S.C. by extension.

2 DR. HAMILTON: In other words, it could be
3 provided through the out-patient department?

4 DR. ATKINSON: It would not be provided through
5 the out-patient department.

6 DR. HAMILTON: It is paid for by the Commission?

7 DR. ATKINSON: Yes. Our feeling is that Bill 163
8 should meet the requirements so that there is no further
9 extension into the practice of medicine in this area. The same
10 applies to radiology where, under the present regulation,
11 certain services in radiology can be paid for under the
12 O.H.S.C.

B/dpw

13 DR. HAMILTON: Could I ask you this: are diag-
14 nostic services available to a sufficient extent outside
15 hospitals? In other words, are there adequate diagnostic
16 facilities apart from those in public general hospitals?

17 DR. BRUCE-LOCKHART: I think the answer to that
18 question is, we did an investigation some time ago, and it
19 was some years ago, there was a considerable amount of diag-
20 nostic services being provided outside hospitals. In fact,
21 the hospital radiologists and pathologists told us that if it
22 was all transferred to hospitals they couldn't cope. You are
23 asking the question the other way around: could outside facili-
24 ties cope with all diagnostic facilities? The answer, I would
25 think, is undoubtedly no.



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1 DR. HAMILTON: Apart from patients in hospitals?

2 DR. BRUCE-LOCKHART: Apart from in-patients,
3 I think the answer would be no. They couldn't deal with all
4 of it. The opposite is equally true, that a patient may be
5 attending a clinic with good x-ray facilities, a radiologist
6 there, x-ray room, and everything else. Unless he goes to the
7 hospital he is not covered for x-rays.

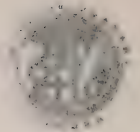
8 MR. SIMON: Do they feel it is unfair competi-
9 tion on the part of the hospital?

10 DR. BRUCE-LOCKHART: It could have been.

11 MR. SIMON: Do you go that far now?

12 DR. ATKINSON: Mr. Chairman, today we have
13 several people who are recognized experts in their field. Dr.
14 Owen Millar, who is a member of our Board and in the practice
15 of radiology, might speak for us because he is the man who is
16 in touch with the problem every day.

17 DR. MILLAR: Thank you, Mr. Chairman. This
18 problem seems like a small part of medical practice and yet it
19 has an important bearing because so much of medical practice
20 depends on correct diagnosis. There is one thing nobody has
21 mentioned at all in this particular area. Dr. Hamilton spoke
22 about it briefly and that is, he suggested could this diagnosis
23 be done out of hospitals and the answer to that was it probably
24 couldn't, and the other answer was it probably couldn't all be
25 done in the hospital.



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1 In actual fact, what happens is the out-patient...

2 THE CHAIRMAN: It all couldn't be done at
3 either place?

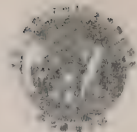
4 DR. MILLAR: We know if artificial work is
5 transferred to the hospital and all out-patients who can walk
6 around and could walk elsewhere as they couldn't as an in-
7 hospital patient - I can speak from experience because I know
8 it is the feeling of hospital radiologists and, I think, patho-
9 logists, that out-patient work interferes with in-hospital
10 practice.

11 The hospital can do one job that nobody can do:
12 that is look after seriously ill people in the hospital. If
13 you artificially by financial means put work in the way of
14 looking after these people properly in the hospital you inter-
15 fere with their care. If you have a large number of out-
16 patients coming to the departments of radiology and pathology
17 you interfere with in-patient work.

18 It isn't necessary for these people to come to
19 hospitals. The work can be done as well in out-patient depart-
20 ments, in private doctors' offices as well as in out-patient
21 facilities in the hospital.

22 I would like to suggest in some cases it is
23 done better.

24 Just to take an example: in the area where I
25 live there are some 200,000 people and one hospital. There are



In actual fact, what happens is the out-patient.

THE CHAIRMAN: It all couldn't be done at

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DR. MILLAR: We know if sufficient work is

transferred to the hospital and not out-patient work, the

ground and right with reference to the hospital is as an

hospital patient - I have never been surprised because I have

it is the feeling of hospital patients and I think having

in fact, that out-patient work is necessary with hospital

practice.

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that is look after seriously ill people in the hospital. If

you sufficiently to hospital work and look in the way of

looking after these people properly in the hospital and

care with their cases. It is not a large number of cases

patients coming to the hospital and looking after them

you interfere with in-patient work.

It isn't necessary for these people to come to

hospital. The only way to look at this is out-patient work

needs, in private practice, as well as in out-patient

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done better.

Just to take an example: in the area where I

live there are about 200,000 people and one hospital. There are



1 five doctors, five radiologists' offices to my knowledge, and
2 I don't know how many general practitioners have x-ray facili-
3 ties, and if overnight the Hospital Services Commission were
4 to say that all people who were insured for all x-ray work had
5 to be in a hospital we couldn't cope in the hospital. It
6 would be a shambles. What would happen, we would turn these
7 people away. It would result in the peculiar circumstance
8 that if you lived in one area of the province you would have
9 value for your insurance and if you lived in another area of
10 the province you wouldn't have value for your insurance.
11 I don't think this is fair.

12 THE CHAIRMAN: Doctors and gentlemen, are you
13 finished? I didn't mean to cut you off. We will take a ten-
14 minute break and reconvene at twenty minutes to five.

15
16 --- Short Recess

17
18 DR. BUTT: Could we continue, and this time
19 call on Mr. Naylor?

20 MR. NAYLOR: Dr. Atkinson, on page 2, this is
21 under Recommendations II, in the first section you have
22 recommended three different standard contracts. In Section 2
23 you have recommended that carriers would be required to offer
24 the Standard In-Hospital and either the Standard or Standard
25 Deductible Contracts. We have had some briefs presented



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THE CHAIRMAN: Doctors and gentlemen, are you finished? I didn't mean to cut you off. We will take a ten-minute break and reconvene in twenty minutes to five.

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DR. HUNT: Could we continue, and this time

MR. HAYES: Dr. Atkinson, on page 2, this is

under Recommendations II, in the first section you have recommended three different standard contracts. In Section C you have recommended that carriers would be required to offer the Standard In-Hospital and either the Standard or Standard Deductible Contracts. We have had some briefs presented



1 which have suggested that the Standard In-Hospital Contract is
2 not a desirable type of contract because for one reason it
3 puts pressure on hospital admission. I wonder if you have any
4 strong or definite reasons for recommending that this In-
5 Hospital Contract be made the mandatory one or would you have
6 any objection if the mandatory one were made in the special
7 contract?

8 DR. ATKINSON: I would ask Dr. Bruce-Lockhart
9 to speak to this.

10 DR. BRUCE-LOCKHART: There are three parts to
11 your question. The first part is why do we recommend this
12 plan, the in-hospital plan. We feel that there are definite
13 requirements for different groups of society. As was explained
14 this morning, some people prefer first-dollar and some people
15 prefer deductible and co-insurance. There are also people who
16 live outside the medical centre who may have a doctor locally
17 and therefore, for practical purposes, their need in that
18 regard is extremely small. It is almost non-existent. What
19 they want coverage for is in-hospital. It seemed to us they
20 should have the benefits of the standard plan normally known
21 as non-cancellable and universally available and so on.

22 We also realize the point which has been raised,
23 this could put some pressure on admission in hospital. The
24 biggest pressure for admission to hospital is really in the
25 diagnostic field. We have recommended this plan to cover not



which have suggested that the Standard In-Hospital Contract is not a desirable type of contract because for one reason it puts pressure on hospital admission. I wonder if you have any strong or definite reasons for recommending that this In-Hospital Contract be made the mandatory one or would you have any objection if the mandatory one were made in the special contract?

DR. ATKINSON: I would ask Dr. Brown-Island to speak to this.

DR. BROWN-ISLAND: There are three parts to your question. The first part is why do we recommend this

standard contract? As was explained requirements for different groups of society. As was explained this morning, some people prefer first-class and some people prefer deductible and co-insurance. There are also people who live outside the medical center who may have a doctor locally and therefore, for practical purposes, their need is that regard is extremely small. It is almost non-existent. What they want coverage for is in hospital. It seemed to me they should have the benefits of the standard plan normally known as non-cancelable and universally available and so on.

We also realize the point which has been raised this could put some pressure on admission in hospital. The biggest pressure for admission to hospital is really in the diagnostic field. We have recommended this plan to cover not



1 only in-hospital but cover the diagnostic service and also
2 consultation. These are the two fairly major items which put
3 pressure to get a patient in the hospital. We think this
4 would relieve them. It would still fulfil the need for a
5 particular group of people who are a fairly small percentage;
6 why should they not have protection that suits them? There is
7 one factor: we feel unlimited diagnostic service could produce
8 a considerable strain on the plan and it would perhaps be
9 better if in this diagnostic service you are dealing with cata-
10 strophic situations for these people. It should have some
11 limit. This gives the doctor a little control as far as the
12 patient saying, "I want this and that type of examination."
13 Those are the reasons.

14 MR. NAYLOR: Actually I wasn't asking that ques-
15 tion. You answered why you were recommending it as one of the
16 three standard plans. I really intended to ask why you
17 recommend it to be the mandatory one. As I understand your
18 Section 2 you are suggesting the carriers be required to
19 offer this to them without option whether they offer one or
20 the other two standard contracts.

21 DR. BRUCE-LOCKHART: The reason for this, sir,
22 is really looking at 1 and 2, really it is the same standard
23 plan with two different methods of payment, and this apparently
24 affects the operation of the plans quite considerably. To
25 compel them to use one or the other would disturb the method



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recommend it to be the mandatory one. As I understand you
Section 2 you are suggesting the service be made to
offer this to them without opinion whether they offer one or
the other two standard plans.
DR. BENTLEY: The reason for this, and
is really looking at it and really it is the same standard
plan with two different methods of payment, and this apparently
affects the operation of the plans quite considerably. To
compel them to use one or the other would disturb the method



1 of operation of some carriers. My understanding of this
2 wouldn't provide too big a problem for them in hospital on
3 first-dollar coverage.

4 DR. ATKINSON: Mr. Naylor, I think it should be
5 explained that what we are recommending here is that there
6 would be two standard contracts that must be covered by a
7 carrier, the In-Hospital Contract and the other Standard or
8 the Standard Deductible.

9 MR. NAYLOR: That is what I gathered your No. 2
10 Recommendation meant. You have answered it to some extent.
11 If we feel, perhaps, the most popular contract, the contract
12 which would be the greatest demand were the standard first-
13 dollar contract have you any very definite reasons - would you
14 have any very definite objections to this being the mandatory
15 one?

16 DR. BRUCE-LOCKHART: We are not too sure how
17 the In-Hospital would operate. I don't think we have consi-
2 18 dered this if it wasn't a standard plan with all the implica-
19 tions in it.

20 MR. NAYLOR: It couldn't be a standard plan.
21 Is there any reason for requiring all carriers to issue it?
22 That is what I am trying to get at.

23 DR. BRUCE-LOCKHART: If you are to support
24 multiple carriers I don't think you would have enough of them
25 offering to the public in this one group. If everybody had



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of operation of the railway, the Government is not
willing to give the railway the right to operate
the railway without the consent of the Government.
The Government is not willing to give the railway
exclusive rights in the operation of the railway.
There would be two standard contracts that must be covered by a
carrier, the In-Hospital Contract and the other Standard or
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DR. BRUCE-LOCKHART: If you are to support
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1 to offer it you would be sure of getting it. The other stan-
2 dard plans, we are sure there are plenty that offer both,
3 anyway.

4 MR. NAYLOR: That is fine on that question.

5 One other question: this goes over to page 10 of the white
6 pages. In Section 33, at the bottom of the page, you refer to
7 the arrangements under which certain carriers have agreements
8 with participating physicians to pay something less than the
9 whole schedule and then you go on to refer to patients going
10 to non-participating physicians and your recommendation is:

11 "They should be indemnified in accordance
12 with the fees set forth in the schedule."

13 When you say "in accordance with the fees set
14 forth" do you mean the full fees? It might possibly be inter-
15 preted as something based on the fees rather than the full
16 fees. Do you mean the full fees?

17 DR. BRUCE-LOCKHART: The full fees.

18 MR. NAYLOR: That is all.

19 THE CHAIRMAN: Mr. Major?

20 MR. MAJOR: Thank you, Mr. Chairman. I have
21 one or two questions which I don't believe are loaded.

22 DR. BRUCE-LOCKHART: We will get at that
23 afterwards.

24 MR. MAJOR: With due respect I recall in your
25 brief before the Royal Commission you set forth a sort of



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the arrangements under which certain carriers have agreements
with participating physicians and then you go on to refer to patients going
to non-participating physicians and your recommendation is:

"They should be indemnified in accordance

with the fees set forth in the schedule."

When you say "in accordance with the fees set

forth" on page 10, that is, it might mean the full
fees. Do you mean the full fees?

DR. THURGOOD-ROCKHAW: The full fees.

MR. MAYHEW: That is all.

MR. MAYHEW: Thank you, Mr. Chairman. I have

one or two questions which I don't believe are loaded.

DR. THURGOOD-ROCKHAW: We will get at that

afterwards.

MR. MAYHEW: With due respect I recall in your

brief before the Royal Commission you set forth a sort of



1 principle you felt should be implemented and that was a great
2 variety of coverages. I wondered at the time about this prin-
3 ciple that was set forth, and in reading your present brief I
4 come to page II of the yellow pages and I wondered how
5 unprincipled the principle is. Having listened to many men in
6 the medical profession, and I am not associating that with any
7 individual association, but they felt that any reasonable
8 medical coverage should take care of preventive services.

9 You, the Medical Association, recommend a
10 deductible plan that would, in all due respect to thinking of
11 it, deter or eliminate ordinary preventive medicine, parti-
12 cularly that kind that would have the use of drugs, inocula-
13 tions, and so on, et cetera. What kind of reason do you put
14 on this other than to lower the rate that is economic or just
15 to sort of get back to the principles you once put to the
16 Royal Commission that you wanted to create a variety of
17 policies available?

18 DR. ATKINSON: Mr. Chairman, I think the point
19 Mr. Major is making is a good one. I think that the person
20 who wants preventive care - and we haven't said preventive care
21 is bad care; we support preventive care most wholeheartedly.
22 If it happens to be a family who have an individual, an age
23 or place where we would, while we would have normal preventive
24 care and preventive care carries throughout the whole of one's
25 life, as a group it is frequently the younger age group and

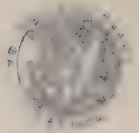




1 the younger families who go and buy the first-dollar benefit.
2 There is nothing to prevent them doing that. The family in
3 the older age group or the couple who are past the normal
4 preventive care will say, "This is what we need," and they
5 are going to go on a trip or something, this is something they
6 can pay for as a small item and still be within the payments.
7 In other words, we are saying that there should be a multipli-
8 city of plans available and that each person should assess his
9 own situation and go and get the thing that suits them. We
10 feel in this province there are people who like deductible
11 co-insurance features. I think the insurance agent and the
12 C.H.I.A. made that point this morning. I think the breakdown
13 of the coverage in the province was there are 50% of the
14 people now insured who like the first-dollar coverage and the
15 other 50% like co-insurance, deductible type of plans.

16 It may be with the passage of time, and none
17 of us can see this far in the future, 25 years from now every-
18 body will have one type or the other. This allows normal
19 economics of competition. It allows good choice of plans to
20 suit the needs of a particular family.

21 DR. BRUCE-LOCKHART: One very simple thing I
22 could say on the matter, is that one principle may come in
23 conflict with another and you have to decide what the
24 principle is - there are people who would pay bills out of
25 their pocket and insure themselves completely; why should



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and the needs of a particular family.

DR. STANLEY: One very simple thing I

could say on the matter, is that one principle may come in

conflict with another and you have to decide what the

principle is - there are people who would pay bills out of

their pocket and insure themselves completely; why should



1 these people be denied the protection they want?
2 MR. MAJOR: Let us pursue it a minute. You
3 heard the evidence this morning from the Canadian Health
4 Insurance Association which appeared to me to be facetious -
5 it seemed presently in the Province of Alberta they were offered
6 the premium that may one day be presented in Ontario and only
7 55-60 of these people took this particular coverage. The
8 percentage is so small it doesn't seem very practical to set
9 up the whole administrative machinery and so on to do this.
10 Do you think it worthwhile to set this administrative machinery
11 up on the matter of principle?

12 DR. SAWYER: Mr. Chairman, I think the question
13 that was asked by Mr. Major this morning was asked on the
14 basis of gossip. It may or may not have been confirmed. I
15 am not quite sure. I would think that this Enquiry would want
16 to try and substantiate whether that was, in fact, true, and
17 if it was true the members of the Enquiry would have to make up
18 their minds whether in the face of this evidence they wanted
19 to offer as a standard plan one with deductibles and co-
20 insurance. It might well be there is evidence to support the
21 fact that it wouldn't be feasible or successful to set it up
22 with all the administrative machinery it requires.

23 THE CHAIRMAN: Could someone here enlighten us
24 as to what the percentage or difference is between the Standard
25 and the Standard Deductible - I mean on an average? Is it



these people be denied the protection they want?

MR. MAJOR: Let us pursue it a minute. You

heard the evidence this morning from the Canadian Health

Insurance Association which appeared to me to be facetious -

it was a very good example of the kind of evidence that we often

hear. The fact is, one day the Government is told that the

55-60 of these people took this particular coverage. The

percentage is so small it doesn't seem very practical to set

up the whole administrative machinery and so on to do this.

Is that the kind of evidence that we are going to have to

live up on the matter of principles?

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that was asked by Mr. Major this morning was asked on the

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to offer as a standard plan one with deductibles and co-

insurance. It might well be there is evidence to support the

fact that it wouldn't be feasible or successful to set it up

with all the administrative machinery it requires.

THE CHAIRMAN: Could someone here enlighten us

as to what the percentage of difference is between the standard

and the standard deduction? I want to know that. Is it



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1 about 10% in cost, 40% in cost? What is the difference here
2 on premiums?

3 MR. NAYLOR: About one-third.

4 MR. DREWRY: One way to determine it is by
5 looking at the recommended maximum premium of the C.H.I.A.
6 presentation which you had this morning. It will give you
7 the proposed maximum premium for the deductible co-insurance
8 contract and the proposed maximum for the first-dollar contract.

9 MR. NAYLOR: About one-third lower.

10 MR. MAJOR: As a matter of education, I would
11 like to determine the difference between ordinary preventive
12 care and care that is given to people of all ages for allergies,
13 to keep them at work. Is this allergy considered treatment
14 service rather than preventive service?

15 DR. ATKINSON: Treatment.

16 MR. MAJOR: This repetitive work would all be
17 eliminated with the fifty-dollar deductible providing nothing
18 else was wrong with the citizen?

19 DR. SAWYER: The citizen has made the alloca-
20 tion, which plan he buys. He knew his condition.

21 DR. ATKINSON: He decides what will suit his
22 circumstances best.

23 MR. MAJOR: You will have anti-selective
24 problems as far as insurance principles are concerned.

25 DR. ATKINSON: I think Mr. Major may be



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on premiums?

MR. MAJOR: About one-third.

MR. DREWRY: One way to determine it is by

looking at the maximum premium of the C.N.A.

proportionately with regard to this matter. It will give you

the present maximum premium for the standard no-accident

contract and the proposed maximum for the first-dollar contract.

MR. MAJOR: About one-third lower.

MR. MAJOR: As a matter of education, I would

like to determine the difference between ordinary preventive

and extra that is given in terms of all the other

in this class of work. Is this already included in the

service rather than preventive service?

DR. ATKINSON: Treatment.

MR. MAJOR: This repetitive work would all be

eliminated by the first-dollar contract which is being

else was wrong with the citizen?

DR. SAWYER: The citizen has made the alloca-

tion, which plan he buys. He knew his condition.

DR. ATKINSON: He decides what will suit his

circumstances best.

MR. MAJOR: You will have anti-selective

problems as far as insurance principles are concerned.

MR. ATKINSON: I agree, Mr. Major, but as



1 wrong in the long run. Whether he is right at the present time,
2 it doesn't look as though with 50% of the people doing this
3 that to have anti-selection might be a very vital factor.

4 THE CHAIRMAN: I have been looking up the
5 rates on this and I just lost track of whether you had passed
6 this or not. Could I go back a moment to the Standard and
7 Standard Deductible you are suggesting? One works out to
8 about \$150 and the other one to about \$192 a year on the basis
9 of the suggested rate by the Canadian Health Association this
10 morning. This applies not to the insured because he has paid
11 for it. It applies to the people who are not able to buy
12 insurance because of age or health reasons, who can't afford
13 to buy it and with only this \$42 difference I would think to
14 this group the reason isn't worth it. Forty-two dollars could
15 be one medical bill. It hardly seems a practical suggestion
16 to me. Do you agree with that?

17 DR. SAWYER: You must take into account what
18 the man will do with the \$42. He might decide to take a
19 policy of extended health benefits with that \$42 and get some
20 of his drugs and nursing and ambulance and appliances and all
21 of those covered. He might feel he was better off with the
22 \$42 and spreading his risk in a catastrophic type of situation.

23 THE CHAIRMAN: I will admit that gives me a
24 wider viewpoint.

25 MR. MAJOR: I doubt if this would be the



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morning. This applies not to the insured because he has paid

at the suggested rate by the Ontario Health Association and

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Standard Health Association and the suggestion. One reason may be

this or not. Could I go back a moment to the Standard and

know on this one I just have to ask of medical people and people

THE CHAIRMAN: I have been looking up the

that to have anti-selection might be a very vital factor.

it seems to me as though with all of the people doing this

around in the long run. Whether or not it is right for the government to



1 position, Dr. Sawyer. Most insurance programs, and I am not
2 acquainted with them all, if a man bought \$50 deductible
3 standard insurance, I doubt if anybody would sell him an
4 extended health plan on top of that as an individual citizen.
5 This would be very anti-selection from an insurance standpoint.

6 MR. NAYLOR: I think, perhaps, I would like to
7 make one comment for clarification. You talk about the
8 difference in premiums. When we said one-third lower than
9 your standard plan it was with \$25 deductible and 20% co-
10 insurance. Mr. Major referred to \$50 deductible which is a
11 plan issued by his organization. I want to be clear the
12 reduction of one-third would be for the \$25 deductible. If
13 it was a \$50 deductible it would be a greater reduction.

14 MR. DREWRY: Just to correct your arithmetic,
15 I think the difference between the two figures you quoted -
16 one is \$11 a month and the other is \$16 a month. The
17 difference is \$60.

18 THE CHAIRMAN: Is this statement correct,
19 however, because I think it is pertinent to the suggestion
20 for the two different plans here...

21 MR. MULROONEY: There is a further error. We
22 are talking about In-Hospital Contract.

23 THE CHAIRMAN: Not in this. This is Standard
24 Deductible with benefits of Schedule A and a defined deductible
25 and co-insurance factor. This is one page 2.



1. Mr. Naylor: I think, perhaps, I would like to
2. make one comment for clarification. You talk about the
3. difference in insurance. When we said we had a lower
4. your standard plan is with the deductible and the
5. insurance. Mr. Major referred to \$50 deductible which is a
6. plan issued by his organization. I want to be clear the
7. deductible of \$50 would be a greater reduction.
8. it was a \$50 deductible it would be a greater reduction.
9. MR. DREWRY: Just to correct your arithmetic,
10. I think the difference between the two figures you quoted -
11. one is \$1 a month and the other is \$16 a month. The
12. difference is \$60.

13. THE CHAIRMAN: Is that correct?
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15. for the two different plans.
16. MR. MULLOONEY: There is a further error. We

17. THE CHAIRMAN: Not in this. This is standard
18. operation with benefit of deductible A and a reduced deductible
19. and co-insurance factor. This is one page 2.



1 MR. MULROONEY: I beg your pardon.

2 THE CHAIRMAN: Is it right that because of this
3 man's health condition, where he wouldn't be able to buy this
4 plan in this medical care bill at this time, that he wouldn't
5 likely be able to buy further insurance beyond the standard
6 deductible premium, that insurance companies generally wouldn't
7 sell him more insurance if he wasn't able to buy regular insurance
8 on a regular basis? Dr. Sawyer, you suggested that one is
9 wiped out?

10 DR. SAWYER: It may be wiped out on an indivi-
11 dual basis. It can't be wiped out on a group basis. I think
12 you could buy from insurance companies, and I think Mr. Naylor
13 earlier said that they did sell this. I could be wrong.

14 THE CHAIRMAN: This risk, you see, a poor risk,
15 a high-cost risk, that is the only one who would buy the
16 standard plan, Standard Deductible.

17 DR. BRUCE-LOCKHART: I don't think there is
18 any question that the standard plan is only going to be bought
19 by high-cost individuals. That is not my understanding of the
20 legislation. This is a plan available to anyone who walks in
21 and asks for it, whether a group, individual or anybody else.

22 THE CHAIRMAN: But the rate that is set is a
23 rate that is presumably higher than the rate required to be
24 paid by an individual who is not in that category.

25 DR. BRUCE-LOCKHART: I think there is one



MRS. MURPHY: I beg your pardon.

THE CHAIRMAN: Is it right that because of this

and the fact that the rate is not in that category,

it is not possible to pay further insurance beyond the standard

likely be able to pay further insurance beyond the standard

deductible portion, and I think that is the case.

Will you please state whether it is possible to pay further insurance

on a regular basis? Dr. Sawyer, you suggested that one is

wiped out?

DR. SAWYER: It may be wiped out on an individual

dual basis. It can't be wiped out on a group basis. I think

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and asks for it, whether a group, individual or anybody else.

THE CHAIRMAN: But the rate that is set is a

rate that is presumably higher than the rate required to be

paid by an individual who is not in that category.

DR. BRUCE-LOCKHART: I think there is one



1 assumption, and I am not an actuary, but I think I am right that
2 the maximum premium collected is actually relatively high as
3 compared to the lowest in this particular deductible one than
4 it is in the first-dollar coverage because you can't charge
5 back against the deductible. I think the maximum premium is
6 relatively higher than the minimum premium in this particular
7 area; am I wrong?

8 MR. NAYLOR: I would hesitate to answer that.
9 I think it is rather complicated.

10 DR. BRUCE-LOCKHART: I think it is right.

11 DR. SAWYER: If you compare it to the rate in
12 Alberta as Dr. Bruce-Lockhart said, these rates are right.

13 THE CHAIRMAN: I have pursued this situation
14 as far as I want to.

15 MR. MAJOR: Gentlemen, you are quite well
16 acquainted with the service principles, how it operates, and
17 so on. On page 10, paragraph 33, it was with rather a shock
18 I read this paragraph. I don't quite understand the direction
19 of your thinking that would bring you to this conclusion.
20 Could you help me?

21 DR. SAWYER: Paragraph 32?

22 MR. MAJOR: 33.

23 DR. SAWYER: The basis of this statement is
24 that physicians have a right, we believe, to enter into agree-
25 ments with service organizations or other organizations if they



the maximum premium collected is actually relatively high as compared to the lowest in this particular deductible one than it is in the first-dollar coverage because you can't charge that against the premium. I think the lowest premium is relatively higher than the minimum premium in this particular area; am I wrong?

MR. NAYLOR: I would hesitate to answer that.

I think it is rather complicated.

DR. BRUCE-LOCKHART: I think it is right.

DR. SAWYER: If you compare it to the rate in

Alberta as Dr. Bruce-Lockhart said, these rates are right.

THE CHAIRMAN: I have pursued this situation

as far as I want to.

MR. MAJOR: Gentlemen, you are quite well

acquainted with the service principles, how it operates, and so on. On page 10, paragraph 33, it was with rather a shock I read this paragraph. I don't quite understand the direction of your thinking that would bring you to this conclusion.

Could you help me?

DR. SAWYER: Paragraph 32?

MR. MAJOR: 33.

DR. SAWYER: The basis of this statement is

that physicians have a right, we believe, to enter into agree-

1 wish to do so. The physician who chooses not to enter into
2 such an arrangement also has a right not to do so. When
3 they get patients who have insurance these patients should
4 expect to be indemnified with the benefits of this Bill.
5 He should not be put to pressure to make doctors partici-
6 pate because the patients are going to have their account
7 paid in full, whereas if they choose on a matter of what-
8 ever reasons they have not to participate that their
9 patients should not be paid for the service as outlined in
10 this Bill 163.

11 MR. MAJOR: As a doctor, would you treat
12 patients under a contract with a carrier that would pay
13 you some percentage less than the schedule knowing that
14 if you cancelled your contract you could get 100% of the
15 schedule? What would be your reason, the logic behind
16 that; why would you say, "I will be a contract physician
17 to this particular carrier and take less than I would get
18 if I weren't a contract practitioner."?

19 DR. SAWYER: I am not sure, Mr. Major,
20 there is any grounds for assuming that the physician who
21 chooses to not participate and being paid 100% is going
22 to do any better financially than the man who participates
23 and gets 90% for every service he renders. This money is
24 not paid to the non-participating physician. It is paid
25 to the subscriber, and the subscribers these days, as I

wish to do so. The physician who chooses not to enter into such an arrangement also has a right not to do so. When they get patients who have insurance these patients should expect to be indemnified with the benefits of this Bill. He should not be put to pressure to make doctors participate because the patients are going to have their accounts paid in full, whereas if they choose on a matter of whatever reasons they have not to participate that their patients would be left in the same position as before this Bill is passed.

MR. MAJOR: As a doctor, would you treat patients under a contract with a carrier that would pay you some percentage less than the schedule knowing that if you cancelled your contract you could get 100% of the scheduled? What would be your reason, the logic behind that; why would you say, "I will be a contract physician to this particular carrier and take less than I would get if I weren't a contract practitioner?"

DR. SAWYER: I am not sure, Mr. Major, there is any grounds for assuming that the physician who chooses to not participate and being paid 100% is going to do any better financially than the man who participates and being paid less. This would be the case if the non-participating physician. It is paid to him as well as the participating physician.



1 think you realize, are a very mobile group of people. If you
2 have to wait for three months for P.S.I. to pay for them they
3 may have gone to Nova Scotia and Newfoundland and it is very
4 difficult to catch up with them. I don't think there is any
5 grounds for saying you are going to be better as a non-parti-
6 cipating physician because you are going to get 100% if the
7 service organization is to pay the subscriber 100%.

8 MR. MAJOR: The practice we are discussing in
9 Bill 163 will not be sold to movers. It will be sold to resi-
10 dents, people who are residents of this province who will buy
11 it. A great majority of the residents of this province have
12 every intention of staying in this province; the best province
13 in Canada.

14 DR. SAWYER: I cannot agree with that, Mr.
15 Chairman. I think if any of you know about people that live
16 in suburban communities - I know the community in which I live,
17 I meet up with young executive types and they are here, and
18 they are residents and employed in an industry, and maybe
19 three months later the industry says, "We want you to go to
20 Vancouver; we want you to go to Montreal, or go some place
21 else." I think people do move around constantly.

22 MR. MAJOR: This class of people don't pay their
23 bills because they have left the province?

24 MR. CASWELL: Just take a little longer.

25 DR. BRUCE-LOCKHART: If I may add a comment to

in Canada.

bills because they have left the province?

DR. BRUCE-LOCKHART: If I may add a comment to



1 this, there is the other side of the question. As Dr. Sawyer
2 said it doesn't seem reasonable to pressure a doctor to take
3 a contract. Similarly, it doesn't seem right to me to pressure
4 a subscriber that he should go to a certain doctor or pay 10%
5 out of his own pocket. I can't see that is reasonable.

/PE/dpw

6 MR. MAJOR: It would be more compatible to
7 everything than to pressure the industry to make a different
8 kind of agreement with the citizen, depending on whether he
9 went to a contract physician or one that wasn't? This you
10 think is all right?

11 DR. BRUCE-LOCKHART: I think the principle still
12 stands that the patient should not be pressurized.

13 MR. MAJOR: We have had a brief put to us - I
14 think it is also in your brief, gentlemen, in respect of
15 psychiatry, and we have been told that in Alberta the Govern-
16 ment-sponsored plan has a one-year waiting period for
17 psychiatry and one visit, which we will call one psychiatric
18 treatment visit per month from then on; whereas, in the
19 submissions in the Province of Ontario, they are setting forth
20 a standard of 50 psychiatric visits per annum as a maximum.
21 In the face of evidence submitted by the Ontario Psychiatric
22 Association that approximately eight to twelve visits rehabili-
23 tates a great majority of the cases, it would seem to me, as a
24 member of this Enquiry, that four times the average is a very
25 high maximum. Have your Association anything in particular to



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1 this, there is the other side of the question. As Dr. Sawyer
2 said it doesn't seem reasonable to pressure a doctor to take
3 a contract. Similarly, it doesn't seem right to me to pressure
4 a subscriber that he should go to a certain doctor or pay for
5 out of his own pocket. I can't see that is reasonable.
6
7 MR. MAJOR: It would be more compatible to
8 everything than to pressure the industry to make a different
9 kind of agreement with the citizen, depending on whether he
10 went to a contract physician or one that wasn't? This you
11 think is all right?

12 DR. BRUCE-LOCKHART: I think the principle still
13 stands that the patient should not be pressurized.

14 MR. MAJOR: We have had a brief put to us - I
15 think it is also in your brief, gentlemen, in respect of
16 psychiatry, and we have been told that in Alberta the Govern-
17 ment-sponsored plan has a one-year waiting period for
18 psychiatry and one visit, which we will call one psychiatric
19 treatment visit per month from then on; whereas, in the
20 submissions in the Province of Ontario, they are setting forth
21 a standard of 50 psychiatric visits per annum as a maximum.
22 In the face of evidence submitted by the Ontario Psychiatric
23 Association that approximately eight to twelve visits rehabili-
24 tate a person who is not ready to be released, it seems to me
25 that in this country, the four-visit system is a very
26 high maximum. Have your Association anything in particular to



1 say about this particular maximum?

2 DR. SAWYER: I think if you wanted to follow
3 that through on the same sort of analogy basis, you could say
4 that the average hospital stay in the Province of Ontario is
5 ten or eleven days, but you get an average by having people
6 who stay longer and people who stay a shorter period of time.
7 In our discussions with the psychiatrists, they agree that the
8 majority of patients require seven or eight or ten treatments
9 and they also say that there are a number of patients who
10 require up to 50 hours in a year. All we are doing is trying
11 to cover that situation. This won't change the fact, I would
12 not suppose, that the average number will still be seven or
13 eight treatments of psycho-therapy.

14 MR. MAJOR: Why put a limit on it at all?

15 DR. SAWYER: Because of the situation with ana-
16 lysts - and I am no expert in this field. But I understand
17 that certain psychiatrists, a very limited number, treat
18 patients by analysis and those patients require four or five
19 treatments a week, for three or four years.

20 Now, if you are going to try and cover that,
21 then you would be into, say, five treatments a week for 50
22 weeks, which would be 250 hours, and the psychiatrists then
23 said that this should not be covered because part of the treat-
24 ment, apparently, is to have the patient accept some responsi-
25 bility for payment and they suggested it be limited to 50 hours.



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said that this should not be covered because part of the treat-

ment, necessarily, is psycho-analysis and that is not covered

policy for payment and they suggested it be limited to 50 hours



1 MR. MAJOR: Is there a difference between
2 analysis and psycho-therapy as far as the payment of the fee
3 is concerned? Will the payment of something help in both
4 cases, or if this mental condition is being treated by psycho-
5 therapy, does this rule out the fact that it has a cure value,
6 the digging into the pocket?

7 DR. SAWYER: I wish you had asked this question
8 of the psychiatrists when they appeared before you.

9 THE CHAIRMAN: I think that this really was
10 asked at that time.

11 MR. SIMON: I asked them and they said it was
12 the best medicine for them to pay money.

13 MR. MAJOR: I am not sure. I am at a loss, from
14 a technical standpoint, as to whether or not a payment by the
15 patient getting psychiatric treatment is more or less effective
16 than payment by the patient who is getting psycho-analysis.
17 So that is the question I want you to answer.

18 DR. SAWYER: I think in their brief they said,
19 their general recommendation was, that all insurance should
20 have a participation factor; so they must have thought there
21 is some value so far as psychiatric services are concerned in
22 having the patients pay something.

23 MR. MAJOR: That is right. They recommended
24 that there should be patient participation in every medical
25 service.



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1 DR. SAWYER: Yes.

2 DR. BRUCE-LOCKHART: I think one point that
3 should be made is that there are some psychiatric illnesses
4 which require psycho-therapy and might require up to 50 hours,
5 but they think that the 50 hours will cover any of those.
6 After that, you are really into a situation of rehabilitating
7 a man psychologically and they think at this point the plan
8 should cease to have the responsibility and the man should
9 accept some responsibility himself. I think this is their
10 saw-off that they are taking because there are a few psychia-
11 tric conditions that may require actual treatment before you
12 start rebuilding the psyche.

13 MR. MAJOR: The professional psychologists in
14 Ontario have a point when they say they should be in the
15 health scheme as far as mental health is concerned.

16 DR. BRUCE-LOCKHART: Now you are into the
17 difference between a psychologist and a psycho-therapist and
18 I can't answer that.

19 DR. ATKINSON: It would have to come from expert
20 people.

21 THE CHAIRMAN: Yes. I think we are asking for a
22 little too much here in asking the Association to speak for
23 one special branch of it.

24 MR. MAJOR: Mr. Chairman, this is a loaded ques-
25 tion and I hope - I do not know whether we can get an answer



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1 for it or not, but time ran short this morning so I couldn't
2 put this question to the Canadian Health Insurance Association.
3 So I am going to see if you fellows are good insurance men.

4 DR. ATKINSON: This is the loaded one?

5 MR. MAJOR: Yes. It has been told to us by
6 many people putting forth presentations here that the addition
7 of various services - and I will name some - optometry, podi-
8 atry, chiropractic, and so on - that by adding these to Bill
9 163, that this is not an extension of health costs - it is
10 only a replacement of what is now being done by a profession
11 that has, apparently, an exclusive right.

12 Now, my question is: do you think that the
13 extension or the addition in this Bill to include podiatry and
14 optometry and chiropractic and osteopathy, and so on, would
15 extend the costs or that it just would replace the services of
16 a medical doctor?

17 DR. SAWYER: I think the answer is very simple.
18 One would assume that by insuring those services, they are not
19 going to provide less services than they are at the present
20 time. So I would think that the additional cost would be the
21 difference between the services they render now and the
22 services they render now which are insured.

23 MR. MAJOR: And there would be an additional
24 cost?

25 DR. SAWYER: There is no doubt of it.



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1 MR. MAJOR: That is all I have, Mr. Chairman.

2 Thank you.

3 THE CHAIRMAN: Miss McArthur?

4 MISS McARTHUR: Thank you, Mr. Chairman.

5 I wonder if I heard correctly, and if not, I
6 would like to have it corrected. On the yellow pages, page
7 VI (22) where we discuss the relationship of legislation --
8 on several occasions in other briefs, we have had an appeal
9 for a comprehensive plan, and I am sure you have read consi-
10 derable about it, of extended benefits, and I wondered if I
11 had heard correctly that you do not think of the medical
12 services legislation Bill 163 as a staging in the development
13 of possibly a comprehensive plan in the future - that you will
14 always feel that this legislation should be separate when it
15 related to medical services? Did I hear correctly?

16 DR. ATKINSON: Yes. Medical services insurance
17 should be separate from any other form of health care insurance.

18 MISS McARTHUR: And at no time become a part of
19 a comprehensive plan of legislation?

20 DR. ATKINSON: No.

21 MISS McARTHUR: Then I did hear correctly.

2 22 DR. SAWYER: I think we should make ourselves
23 quite clear, that this does not say that we would oppose the
24 development of insurance to cover other areas. I think we
25 have to make ourselves quite clear on this.



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1 THE CHAIRMAN: When you say medical services,
2 then you are talking of medical services in the content and
3 the way in which it is defined within this Act, which is
4 really the services of physicians?

5 DR. SAWYER: Personal services of a physician.

6 THE CHAIRMAN: And that this should be, in your
7 opinion, a separate Act, regardless of what else might be done
8 in extending support for other types of medical services?

9 DR. SAWYER: Other types of health care.

10 DR. BRUCE-LOCKHART: Just to give an example
11 of our thinking here - supposing you were to tackle a drug.
12 Drugs, for instance, in every country that has tried it, has
13 proved an extremely unmanageable and extremely difficult thing.
14 They have had to put on deterrents. They have found it has
15 been a very considerable headache. It seems to me that if you
16 were to add this into this particular insurance you would
17 merely complicate a picture which is already complicated
18 enough because we do not know what the best method of insurance
19 of a physician's services is and it doesn't necessarily mean
20 that you couldn't make some attempt to cover drugs under
21 different headings.

22 THE CHAIRMAN: If this were done you would be
23 interested. Are you not saying here that you would necessarily
24 oppose it?

25 DR. BRUCE-LOCKHART: No.



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1 THE CHAIRMAN: You would probably be willing to
2 co-operate in the establishment of it, but as a separate Act?

3 DR. BRUCE-LOCKHART: That is correct.

4 MISS McARTHUR: Have you thought of the necessity
5 for some co-ordination of legislation in the broad health
6 field?

7 DR. ATKINSON: I think you would have to look
8 at it from several aspects. Our Association has always had a
9 very broad interest in the matter of health care. When you get
10 into the financial aspects of it, though, it has many ramifica-
11 tions that would take many hours to study and I think that
12 this would require some delineation and study.

13 MISS McARTHUR: That answers that question, sir.
14 I think my public cap is showing a bit today and it has all
15 the way through the briefs. I still have some difficulty with
16 the exemption worded "any health examination" in my thinking
17 because it does, to me, negate some of the things that public
18 health has struggled with for some time. My question was, for
19 instance, individuals that have family histories that would
20 indicate that there should be periodic examinations, rather
21 strenuously, and maybe rather frequently; also in the area of
22 follow-up in some conditions after there has been an apparent
23 cure. I am wondering if these would come under your handling
24 of general services and what the criteria would be and how one
25 would decide whether - a review board, or what, would decide



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1 whether the decision was the correct one or not?

2 DR. ATKINSON: There are many areas that you
3 have referred to in your question. If I might take the ques-
4 tion of follow-up. I think the follow-up of a person following
5 an operation for cancer could not be construed as a periodic
6 health examination in the sense that the patient has no
7 symptoms. That patient, I think we would all maintain, has a
8 symptom when they had treatment for and signs of a carcinoma
9 that has been treated. We know that the natural history of
10 the course of cancer is the ultimate demise of that patient
11 and I think that this is an area that would be accepted.

12 Now, you get into other areas and I think that
13 this is a matter of interpretation and I think this is why we
14 have recommended an advisory committee.

15 MISS McARTHUR: You would see this board as
16 having one of the functions of establishing criteria in rela-
17 tion to...

18 DR. ATKINSON: This would have to be delineated
19 in some detail and make decisions as to what are not periodic
20 health examinations and what would be reasonable care.

21 MISS McARTHUR: This committee, the advisory
22 committee, you would see establishing also, if a problem did
23 arise, criteria in relation to the exemption as you outline on
24 page 42, Exemption 5. You have re-worded that one as well,
25 changed the wording to those "conditions that do not interfere



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2 that it should be re-worded in relation for a purely cosmetic
3 purpose. Purely cosmetic purposes might be construed in a
4 great many ways, might it not?

5 DR. SAWYER: When this was discussed, we had
6 some discussion with various insurers and the impression we
7 got was that the majority of insurers had to pay for most of
8 the services in this particular area because sometimes there
9 is psychiatric indications for corrective surgery. They
10 seemed to feel that they were going to have to pay for that,
11 too. But we felt that there should be some basis to start an
12 argument in one that looked as if it was purely cosmetic,
13 without any supporting evidence from any physician that it was
14 necessary medical care.

15 MISS McARTHUR: I was rather wondering on page
16 39, under 140, "Services that a covered person receives." I
17 was wondering in (IV) you have got into discussion about,
18 again, well-baby care and your brief, to my mind, indicated
19 that you were leaving public health - or indicating that these
20 public health actions should be taken care of by government
21 rather than through private practice; am I correct there in
22 that?

23 DR. ATKINSON: If I might just speak briefly on
24 this, Mr. Chairman. Taking the area of well-baby care, under
25 the terms of the benefits of the Act, a certain number of



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the terms of the benefits of the Act, a certain number of



1 well-baby care visits would be recognized and our understanding,
2 and I believe it was the presentation yesterday that P.S.I.
3 said that the figure that they arrived at was made on the
4 recommendation of paediatricians, that this covered the normal
5 course of a child under the age of 5. Now, this covers the
6 normal preventive health care in that early age group. Some
7 people may wish to have this care provided by a well-baby
8 clinic that is operated by a municipality and this exemption
9 here would exclude the payment of insurance monies where the
10 well-baby clinic would normally make no charge. In other
11 words, they couldn't select against an insuring agency. They
12 would either have to charge everybody coming and collect from
13 the insuring agency or the patient.

14 DR. SAWYER: I think that is a good example.
15 It is just that their policy has to be one thing or the other
16 and they can't just charge the people that have insurance.

17 MR. MAJOR: For clarification, did I understand
18 you to say, Dr. Atkinson, that the Bill as it now stands covers
19 well-baby care?

20 DR. ATKINSON: I think we have outlined it here.

21 MR. MAJOR: No. The Bill as it stands now?

22 DR. SAWYER: It is not an exception.

23 MR. MAJOR: And it is not covered because the
24 exception rules out health examinations. The way the Bill is
25 written now, there is no well-baby coverage in it because of

MR. MAJOR: And it is not covered because the



1 the exception?

2 DR. ATKINSON: We assumed that it was covered
3 because the paediatricians say that a child in the first five
4 years is changing rapidly. His demands for food, his rate of
5 growth, et cetera, are such that this could not be construed
6 in the sense of a normal periodic health examination, in the
7 sense when you or I would go to our physician and ask for an
8 examination - because we had no particular complaint, we just
9 thought, well, it was that time of year sort of thing.

10 MR. MAJOR: I agree with your scientific
11 approach but from an insurance standpoint of the terms and
12 conditions set forth in Bill 163, I doubt very much if you
13 could make that stick without bringing forth a stronger argu-
14 ment than that well-baby care is covered in this Bill.

15 DR. SAWYER: Maybe we should say that we assumed
16 that it was covered and if it is not covered, we think it
17 should be covered.

18 MR. CASWELL: During that period of time,
19 wouldn't that baby be treated just like any other patient -
20 just a regular call, if the family is covered for insurance
21 under the standard plan?

22 MR. SIMON: The baby would have to complain
23 about something.

24 DR. ATKINSON: This is the reason for our
25 assumption that well-baby care was covered, because the infant



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THE FOLLOWING

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1 could not compalin and he must rely on the diagnostic skill of
2 the physician.

3 MR. CASWELL: I am suggesting that the insurance
4 plan now covers the baby just as it would cover the mother.
5 In other words, a new-born baby is born and over the next
6 three years the mother takes that baby regularly to the doctor
7 and the insurance plan covers it.

8 DR. SAWYER: We assumed this.

9 MR. MAJOR: Well-baby care is practically health
10 education, Mr. Chairman. Let us take a family of ten children,
11 and there are hundreds of cases to prove the point. The first
12 two children get well-baby care and the rest don't. The mother
13 is now educated. She does not need a medical man any more.

14 DR. SAWYER: I think the big point in well-baby
15 care is the picking up of congenital anomalies; for instance,
16 a congenital heart that you can treat now by surgery, and things
17 of this sort. I think this is the big advantage of well-baby
18 care.

19 THE CHAIRMAN: It doesn't seem to make much
20 difference to me, because it is too easy to get around, anyway.
21 You could take your child to the doctor and say he is not
22 feeding properly or sniffing, or something like that, and you
23 have got the same thing.

24 MISS McARTHUR: On page 47, in your Suggestion
25 2, in relation to diagnostic services: if the O.H.S.C.



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MISS McARTHUR: On page 47, in your suggestion

have got the same thing.

You could take your child to the doctor and say he is not

difference to me, because it is too easy to get around, anyway.

THE CHAIRMAN: It doesn't seem to make much

case.

of this sort. I think this is the big advantage of well-baby

care is the picking up of congenital anomalies; for instance,

DR. SAWYER: I think the big point in well-baby

is now educated. She does not need a medical man any more.

and children are well-baby care and the rest of it. The doctor

and the rest of it. The doctor and the rest of it. The doctor

education, Mr. Chairman. Let us take a family of ten children,

MR. MAJOR: Well-baby care is practically health

DR. SAWYER: We assumed this.

and the insurance plan covers it.

these babies and doctors have been baby regularly to the doctor

In other words, a new-born baby is born and over the next

insurance covers the baby just as it would cover the mother.

MR. CASWELL: I am suggesting that the insurance

the physician.



1 extended its benefits to home care programs, would you see this
2 service, this benefit here, taking care of the medical services
3 plan? Was that one of the factors?

4 DR. ATKINSON: In a home care program?

5 MISS McARTHUR: Yes; in a home care program?

6 DR. ATKINSON: Yes. This would pick up the
7 diagnostic services in a home care program.

8 DR. SAWYER: I think we should say, though, Mr.
9 Chairman, that a hospital-based home care program assumes
10 responsibility for people who have been in hospital and this
11 is not, in our opinion, the best type of home care program.
12 We think a home care program should keep people out of hospital,
13 rather than only looking after the people who have been in the
14 hospital, in the home.

15 THE CHAIRMAN: May I ask you a question,
16 following up the one that Miss McArthur asked you, about your
17 recommendation, that this Act, or an Act along this line, be
18 a separate Act for physicians' services only. If the Govern-
19 ment decided - and you recall that refractions are permissible
20 in Schedule A here - and if the Provincial Government decided
21 that refractions, as done by optometrists, were eligible, would
22 you then say that this should be a separate Act for that?

23 DR. ATKINSON: Yes.

24 THE CHAIRMAN: This is without regard to your
25 opinion as to whether optometrists should or should not be



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extended its benefits to home care programs, would you see the
service, this benefit here, taking care of the medical service
plans? Was that one of the factors?

THE CHAIRMAN: Is it a question of service?

MISS McARTHUR: Yes; in a home care program?

DR. ATKINSON: Yes. This would pick up the

diagnostic services in a home care program.

DR. SAWYER: I think we should say, though, Mr.

Chairman, that a hospital-based home care program assumes

responsibility for people who have been in hospital and this

is not, in our opinion, the best type of home care program.

THE CHAIRMAN: I am not sure that is the best type of home care program.

rather than only looking after the people who have been in the

hospital, in the home.

THE CHAIRMAN: May I ask you a question?

Following up the one that Miss McArthur asked you, about your

recommendation, that this Act, or an Act along this line, be

a separate Act for physicians' services only. If the Govern-

ment decided - and you recall that refractions are permissible

in Schedule A here - and if the Provincial Government decided

that refractions, as done by optometrists, were eligible, would

you then say that this should be a separate Act for that?

THE CHAIRMAN: Yes.

THE CHAIRMAN: Yes.

opinion as to whether optometrists should or should not be



1 included. But I am simply saying that if the decision were
2 made, on the part of the Government, that refractions could be
3 paid for under Schedule A here, if done by optometrists, then
4 do you think that this should be a separate Act?

5 DR. ATKINSON: This should be quite separate and
6 apart from the Medical Services Insurance Act.

7 MR. MULROONEY: On page 10, paragraph 32, this
8 paragraph relates to payment of 90% of the O.M.A. fee schedule
9 to the participating physicians in a doctor-sponsored plan.
10 You are suggesting that the proportion of payment of 90% be
11 continued. Why does the Ontario Medical Association wish
12 doctors paid 90 cents out of a dollar?

13 DR. SAWYER: With respect, sir, we have not
14 said that. All we have said here is that if the majority of
15 physicians in an area wish to enter the agreement, they should
16 be permitted to do so.

17 MR. MULROONEY: This is perfectly so and the
18 agreement relates to pro-ration of the fee schedule. Now, we
19 are here talking of a new contract, the Standard Contract,
20 which the carriers shall be obliged to underwrite under the
21 law that is in prospect. This does not relate to contracts
22 presently in effect or underwritten by any carriers and it
23 seems puzzling to me that the Ontario Medical Association,
24 because there are agreements related to other contracts,
25 should wish to carry the conditions already existing with



included. But I am simply saying that if the decision were made, on the part of the Government, that restrictions could be made for labor service, it would be a separate Act?

DR. ATKINSON: This should be quite separate and apart from the Medical Services Insurance Act.

MR. MURROONEY: On page 10, paragraph 32, this paragraph relates to payment of 90% of the O.M.A. fee schedule to the participating physicians in a doctor-sponsored plan. You are suggesting that the proportion of payment of 90% be continued. Why does the Ontario Medical Association wish doctors paid 90 cents out of a dollar?

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1 respect to other contracts and to new contracts that carriers
2 must underwrite because the Government says they will be under-
3 written?

4 DR. BRUCE-LOCKHART: I think if a group of
5 doctors wish to enter into an agreement to provide benefits
6 of a standard plan and accept 90% of the fee schedule as pay-
7 ment, this seems to us their prerogative; but we do not think
8 that the patient should be penalized and this is why we have
9 put this in. We do not think the patient should be penalized
10 by being limited to going to those doctors.

11 MR. MULROONEY: Why should the public carriers
12 be penalized to the extent that they would be required to pay
13 more than the doctor-sponsored plan, if their subscribers are
14 served by the same doctors?

15 MR. MAJOR: I think what Mr. Mulrooney is saying,
16 Mr. Chairman, is that Bill 163 should have a clause in it that
17 all other contracts, notwithstanding, shall become subservient
18 to this one and maybe that is not good legality; but the intent
19 would be to kill any contract that might be made with a
20 carrier.

21 MR. MULROONEY: This is not what I said, Mr.
22 Chairman, at all. We are here dealing with a new contract
23 which does not affect other contracts now in force. Why
24 should the medical practitioners, in relation to other
25 contracts, who have signed agreements with any carrier, be

must underwrite because the Government says they will be under-
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1 obliged to have this same condition carry over into a new
2 contract imposed on carriers by government?

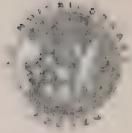
3 DR. BRUCE-LOCKHART: I will answer that another
4 way. If a group of doctors chose - it might be in a rural
5 area, it might be with a private carrier in that area - if
6 they chose to sign an agreement with that carrier to provide
7 the benefits of Schedule A at 70% or 50%, it seems to me this
4 8 should be their prerogative because the patient is getting the
9 benefits which is the benefits of the standard plan.

10 Now, if a doctor says, "We would only like to
11 do this where we run the organization," that is still the
12 doctors' business.

13 MR. MULROONEY: I will agree that the doctor
14 has a perfect right to sign any type of agreement that he likes.
15 I have looked at the agreement signed with P.S.I. and it means
16 that he takes what he gets and he has no rights whatever in
17 disputes.

18 DR. SAWYER: He has the right to become a non-
19 participating physician.

20 THE CHAIRMAN: Would it be within the realm of
21 possibility that Medical Carriers Incorporated might enter
22 into an agreement with all or a group of surgeons or physicians
23 to accept this special fee, which is less than the regular fee?
24 Not that I am saying that this might happen, but is it beyond
25 the realm of possibility, in your thinking?



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DR. BRUCE-LOCKHART: I will answer that another

way. If a group of doctors want to go into a new

way, it might be wise to provide a certain in that way - if

they choose to sign an agreement with that carrier and provide

the details of a schedule as you say, it seems to me that

should be their prerogative because the carriers are feeling the

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that he knows what he gets and he has no right whatever to

dispute.

DR. SAWYER: He has the right to become a non-

participating physician.

THE CHAIRMAN: Would it be within the realm of

possibility that medical carriers be organized along similar

lines as agreement with all or a group of carriers or providers

to arrange this special fee, which is less than the regular fee?

But that I am saying that this might happen, but it is not

the realm of possibility, is your thinking?



1 DR. BRUCE-LOCKHART: I can answer that in two
2 ways: (1) if the doctors wanted to do it, we certainly couldn't
3 stop them, and, secondly, I do not think, in the present
4 concept of Medical Carriers Incorporated that it is more than
5 a technical body for coping with the arrangements between
6 carriers to make the present Bill effective. It is not, in
7 our concept, an insuring agency and I do not think it is in
8 the C.H.I.A.'s concept.

9 THE CHAIRMAN: I think that is right. But I
10 believe it is set up as a corporation. Probably a corporation
11 could assume this power.

12 DR. ATKINSON: As we understand it, it is a
13 corporation, so it can fulfil the normal functions of a corpo-
14 ration.

15 DR. BRUCE-LOCKHART: This is one of the reasons
16 we felt that the terms of reference should be spelled out in
17 the Act.

18 MR. MULROONEY: I have no further questions.

19 THE CHAIRMAN: Mr. Simon?

20 MR. SIMON: Thank you, Mr. Chairman. On page 6
21 you say, in paragraph 19, Dr. Atkinson:

22 "Where a carrier issues a standard medical
23 services insurance contract, or a standard
24 deductible medical services insurance contract,
25 or a standard in-hospital medical services



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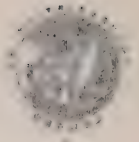


1 insurance contract, it may, by rider to the
2 contract for an additional stated premium
3 and not otherwise, provide benefits greater
4 than those set forth in Schedules A and B."

5 Now, can I take that to mean that if any carrier,
6 whether it is P.S.I. or an insurance company, shows a reasonable
7 profit and they wish to extend greater benefits to their
8 insured people, they cannot do it other than by charging extra
9 money for it? That is the interpretation I give this.

10 DR. SAWYER: No. The interpretation here, Mr.
11 Chairman, is a protection to the public. Bill 163 says that
12 the benefits of standard contracts cannot be sold for a premium
13 greater than that stipulated in the Act. Unless you do it the
14 way it is suggested here, you could have a carrier go to a
15 subscriber and say, "Here is a policy, it has benefits greater
16 than the standard contract," and if the maximum premium is \$6,
17 they could say, "We will charge you \$9." All we are saying
18 here is that they have to take the benefits of the standard
19 contract and put a price on it. So you can assure the
20 subscriber that the price for the benefits of the standard
21 contract are not greater than those set down in the Act, and
22 then they have to put a price on the remainder of the benefits.
23 This is for the protection of the public.

24 MR. SIMON: My interpretation of this is that
25 if there is additional benefits there has to be extra money



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insurance contract, it may, by rider to the contract for an additional stated premium and not otherwise, provide benefits greater than those set forth in Schedules A and B."

Now, can I take that to mean that if any carrier wishes to extend its business, it must, under the Act, profit and they wish to extend greater benefits to their insured people, they cannot do it other than by charging extra money for it? That is the interpretation I give this.

DR. SAWYER: No. The interpretation here, Mr. Chairman, is a protection to the public. Bill 163 says that the benefits in the Act are not to be greater than that stipulated in the Act. Unless you do it the way it is suggested here, you could have a carrier go to a subscriber and say, "Here is a policy, it has benefits greater than the Act, and we will charge you \$9." All we are saying here is that they have to take the benefits of the standard contract and put a price on it. So you can assure the subscriber that the price for the benefits of the standard contract are not greater than those set down in the Act, and then they have to put a price on the remainder of the benefits. This is for the protection of the public.

MR. SIMON: My interpretation of this is that



1 charged for it?

2 DR. SAWYER: There will have to be extra money
3 and they have to be set down in two packages, so that they
4 can't charge more for the standard benefits than stipulated in
5 the Act. This is legal phraseology and I must admit that it is
6 not always clear to me.

7 MR. SIMON: Would you agree that they can give
8 greater benefits for the same amount of money?

9 DR. SAWYER: Yes, as long as it does not exceed
10 the maximum premium.

11 MR. SIMON: I will go along with that.

12 DR. GALLOWAY: I was just going to help bring
13 that point out.

14 DR. ATKINSON: The other point is that for the
15 operation of M.C.I., these contracts would have to be separate.

16 MR. SIMON: My next question is: on page 10,
17 paragraph 32, you talk about choice of physicians, and so on.
18 You say:

19 "It is equally well known that not all physi-
20 cians participate with those carriers because
21 of a preference to deal directly with their
22 patients. Bill 163 should provide for both
23 situations."

24 What about indigent cases, where they go to a
25 doctor who is not a participant? In that case they would have
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1 DR. SAWYER: We're not talking about the medical
2 welfare plan, because over the years that we have run the
3 medical welfare plan, in fact since 1935, doctors all partici-
4 pated, and accepted the payments that were made by it.

5 MR. SIMON: Supposing it's a subsidized person,
6 who hasn't got the cash at the time when he goes to visit the
7 doctor, and the doctor says, "I'm not a participating physician
8 in any of the Government insurance plans."

9 What would he do then?

10 DR. BRUCE-LOCKHART: Well, this is a very
11 simple matter, because this is a normal procedure in practice.
12 This is one of the reasons to have identification. Whether
13 you are a participating doctor or not in a government plan,
14 which is our impression that the vast majority, if not all
15 doctors, will accept the government payment, if he knows who
16 they are, if he cannot pay the cash he would merely say to the
17 patient, "Well, whatever the Government will pay you, you pay
18 me." That's all.

19 MR. SIMON: I'm interested in a person that
20 goes to a doctor, and hasn't got the cash to pay.

21 DR. BRUCE-LOCKHART: The principle of dealing
22 directly with your patient is that you make the contract
23 between the patient and yourself. Now, that doesn't mean that
24 you want cash on the nail. If the patient is a P.S.I. patient,
25 and the P.S.I. normally pays within two or three months, then



1 if the doctor is not participating, the cheque is sent to the
2 patient, and it's up to the patient to bring the cheque to the
3 doctor.

4 That's all that dealing with direct means.

5 MR. SIMON: On page 11, at the bottom, and
6 continuing on page 12, you say:

7 "It should not be assumed that the payment
8 of the fees recommended will, in all cases,
9 be considered by those rendering the services
10 as full payment for those services."

11 I wondered, first of all, if you could give us
12 the figures? How many of your member doctors charge more than
13 the recommended schedule of fees by your Association? Are
14 there such figures available?

15 DR. ATKINSON: There would be no figures
16 available, Mr. Chairman, and one doctor in his own practice
17 might deal differently with one patient as compared with
18 another patient.

19 I would suggest, Mr. Chairman, that in discus-
20 sion with members of the insurance agencies that in the
21 province there are very few doctors who aren't accepting the
22 schedule as the full payment.

23 We've stated quite clearly that the fee schedule
24 is a guide, and I've repeated into the record the College's
25 viewpoint of the factors which are dictating a doctor's



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statement of the association which are the doctor's



1 rendering of a fee.

2 MR. SIMON: I am concerned with the point of
3 view of an insured person who pays for a policy, and he has
4 every right to expect when he goes to see a doctor that this
5 premium is paid for the services.

6 There are more and more people who are being
7 insured, and more and more people will take the same view,
8 the same as I'm insured against fire hazard, or anything else,
9 and if something happens I collect.

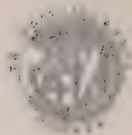
10 If something happens, I expect that my insurance
11 will cover me when I go to see a doctor.

12 DR. SAWYER: Mr. Chairman, we've set out in
13 paragraph 40 some of the situations that we think will not
14 hold, and why we think so, and I think that it's the thought
15 of the Association that the doctor will tell the patient, first
16 what his fee will be, so that the patient will be aware that
17 the insurance will not cover ---

18 MR. SIMON: Well, you certainly destroy the
19 entire intent of insurance when you go to a doctor who charges
20 more than what the insured price is.

21 DR. ATKINSON: I think Mr. Simon is confusing
22 prepayment and payment in full, and these two areas are quite
23 different.

24 DR. BRUCE-LOCKHART: You see, Mr. Simon, you
25 have to take one or two factors into consideration. The idea



Transcript of a hearing

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If something happens, I expect that my insurance

will cover me when I go to see a doctor.

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our report no more of the insurance than we think will be

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prepayment and payment in full, and these two areas are quite

different.

DR. BRUCE-LOCKHART: You see, Mr. Simon, you

have to take into account the fact that the doctor



1 that you hold, that one should be able to prepay entirely one
2 complaint, you would have to make individual arrangements for
3 individual localities. You would then have to work out within
4 those localities the roll of seniority, and so forth, which
5 would be quite cumbersome.

6 We're talking about central agencies giving
7 this coverage. One should not try to make that absolute.
8 Some people would demand custom tailoring, rather than a suit
9 off the rack, and there's all the difference in seniority,
10 and experience, and so on.

11 THE CHAIRMAN: Doesn't this strengthen the
12 suggestion which you made that there should be some form of
13 identification for those patients coming in who are under a
14 totally subsidized program, and not realizing probably, and
15 not having given it the attention that they would if they
16 were paying for it themselves, because they are getting it for
17 free, just taking it for granted that this is all covered, no
18 matter what doctor they go to?

19 So they go to a specialist in the case of
20 obstetrics, as you mentioned, expecting that they are covered,
21 but then they have no way of identification, and the physician
22 doesn't recognize them as being in a class where he could
23 expect payment of his regular fees, and goes on to perform the
24 service, rather than get into an embarrassing situation.

25 Now, under the present system, isn't it right



1. The question of the role of the individual in the
2. community, you would have to make individual studies of the
3. individual localities. You would have to make studies of the
4. those localities the role of seniority, and so forth, which
5. would be quite cumbersome.

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10. and experience, and so on.

11. The question is whether or not the individual is the
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13. identification for those patients coming in who are under a
14. locally established program, and not making a study of
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20. obstetrics, as you mentioned, expecting that they are covered,
21. but when they go to the hospital, and the hospital
22. doesn't recognize them as being in a class where he could
23. make a study of the hospital itself and how the hospital can
24. service, rather than get into an embarrassing situation.
25. Now, under the present system, isn't it right



1 that the people who do qualify for Ontario medical welfare plan
2 do have some identification when they come in, and this would
3 cover a large percentage of the indigents at the present time,
4 so that the embarrassment would not be much greater, you
5 wouldn't embarrass many more people if they did require identi-
6 fication for all those under a subsidized program?

7 DR. MELVIN: I think in a way this is a deter-
8 rent. I'm not being flippant, but I had to remove a wart from
9 a patient, and he had the general practitioner come in and
10 literally hold his hand, and we bill insurance companies for
11 those doctors' time.

12 A patient in hospital for 90 days has a 30-
13 minute visit each day. He's demanding too much, and one way
14 to stop him is to bill him, and not bill the insurance company
15 for a 30-minute visit for 90 days in a row.

16 MR. SIMON: I can understand this situation,
17 but I'm talking about the normal situation, where a man goes
18 to a doctor, and he expects, and he has every right to expect,
19 in my opinion, that his premiums cover him.

20 DR. MELVIN: In the bulk of situations this is
21 what happens. A reasonable patient expects it, and most people
22 in the province, I think, do. Not all, because some do over-
23 bill.

24 MR. SIMON: Well, I suggest you strengthen your
25 union a little bit.



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to a doctor, and he expects, and he has every right to expect,
in my opinion, that his premiums cover him.

DR. MELVIN: In the bulk of situations this is
...A reasonable patient expects to, and many people
...that all because some do not
bill.

MR. SIMON: Well, I suggest you strengthen your
union a little bit.



1 On page 22, paragraph 73, you deal with the
2 totally subsidized group, and you suggest that you believe
3 that the plan should be administered by your Association.

4 Would you have any objections that there should
5 also be some participation in that administration -- after all,
6 the Government is going to pay the money.

7 DR. SAWYER: Mr. Chairman, we have a contract
8 with the Department of Public Welfare, and this contract gives
9 the Department of Public Welfare the right to come in and
10 examine our administration, examine our accounts, and partici-
11 pate from a government point of view, to see that the money is
12 being wisely spent.

13 There's also provision for the Committee of
14 Government in our Association to sit down. There may be
15 significance there, that since it started I don't know of any
16 time that that Committee has met. It certainly hasn't in the
17 twelve years I've been with the Association.

2 18 It may be significant also that the only time
19 they come and look at our books and administration is when
20 we're trying to renegotiate the contract.

21 It may be also significant that the last time
22 we saw the Minister of Public Welfare he said he hadn't had a
23 complaint at any time about the doctors with reference to these
24 people.

25 MR. SIMON: Somebody has made reference to



On page 22, paragraph 73, you deal with the
totally unorganized group, and you suggest that the
that the plan should be administered by some authority.
Would you say that the plan should be administered by some authority?
Also on some point in the plan administration - after all
the Government is going to pay the money.
DR. SAWYER: Mr. Chairman, we have a contract
with the Government of Canada, and this contract gives
the Government of Canada the right to come in and
take over administration, including all personnel and facilities.
from the Government point of view, for the time being it
being wisely spent.
There's also provision for the Committee of
Government in our Association to sit down. There may be
significant points, and I think it would be worth it to
time that the Committee has met. It certainly seems to me
twelve years I've been with the Association.
It may be significant also that the only time
they come and look at our books and administration is when
we're trying to renegotiate the contract.
It may be also significant that the last time
we saw the Minister of Public Welfare he said he hadn't had a
complaint at any time about the Society with reference to
people.

MR. SIMON: Somebody has made reference to



1 interference to the doctors by the Ontario Hospital Insurance
2 Commission -- well, I shouldn't say interference, but the
3 statement was made that there were no facilities, or lack of
4 facilities.

5 Was it any better before there was an Ontario
6 Hospital Insurance Commission as far as the hospitals are
7 concerned?

8 DR. MELVIN: Well, it was happier, because you
9 knew who you had to fight with then.

10 MR. CASWELL: We found that out here.

11 MR. SIMON: I just wanted to compliment the
12 Association for some of the suggestions that I've been trying
13 to promote here. I really mean it. Your proposition, or your
14 suggestion on the Arbitration Board, on the Advisory Committee,
15 on drugs for subsidized patients, and even the inclusion of
16 well-baby care. I would rather have it spelled out than to
17 trust these insurance company people for it.

18 THE CHAIRMAN: Are there any other members of
19 the Enquiry who have questions?

20 MRS. AYLEN: This is on the subject of drugs,
21 too, and on page 41, Item 145, you indicate that really it
22 shouldn't be under the Act, but that there should be provision
23 for patients who need it, and you go on to state the different
24 ways that people obtain these drugs; then, when you come up to
25 Item 147, you recommend:



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information to the doctors and the hospital insurance
Commission -- well, I shouldn't say information, but the
statement was made that there were no facilities, in lack of
facilities.

Was it any better before there was an Ontario
Hospital Insurance Commission as far as the hospitals are
concerned?

DR. MELVIN: Well, it was happier, because you
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MR. SIMON: I just wanted to compliment the
Association for some of the suggestions that they have been trying
to promote here. I really mean it. Your proposition, or your
suggestion in the Association Board, or the Hospital Commission
on things like subsidizing patients, and even the creation of

well-paid staff. I really think that it spelled out that we
trust these insurance company people for it.

THE CHAIRMAN: Are there any other members of
the Board who have questions?

MRS. ALLEN: This is on the subject of drugs,
too, and on page 41, Item 145, you indicate that really it
shouldn't be under the list, but that there should be provision
for patients who need it, and you go on to state the different
ways that there is to obtain these drugs, that you come up to

Item 147, you recommend:



1 "147. The Committee also drew attention to
2 the problem of patients with marginal incomes,
3 (those who would be eligible for partial
4 subsidy to purchase medical services insurance
5 by our method of determination). It was felt
6 there were prescriptions given by physicians
7 which were never presented or filled by the
8 pharmacist because of the cost factor. The
9 extent of this problem was difficult to assess.

10 "148. We recommend, therefore,

11 "THAT government give early considera-
12 tion to a plan whereby subsidized
13 patients will be assured of getting
14 necessary drugs."

15 On what basis do you recommend that they get
16 them, on a necessary, or would there be any limit, because I
17 see that in (2) of Item 146 you say that the limit should be
18 \$20 per person per month. Would that be \$240 a year, or is it
19 worked out on a monthly basis?

20 DR. SAWYER: That \$20, Mr. Chairman and Mrs.
21 Aylen, is the amount which can be given on behalf of these
22 people for all the extras. For some it might be drugs. It
23 might be extra fuel, or clothing, or something, and it could
24 be two-hundred and forty in a year, that a family had some
25 particular set of circumstances.



1 Now, when you come to the question of how you
2 would handle drugs, we haven't any recommendation in this area,
3 but I think the Government accepted and gave consideration to
4 the suggestion, that there is certain information available for
5 a basis of study. For instance, in the City of Toronto for
6 the last couple of years they've worked out a plan with the
7 Retail Pharmacists' Association, whereby the prescriptions are
8 filled at the ordinary drugstore, and they go in and are
9 handled, I assume, much as the medical welfare plan.

10 I think they have a similar arrangement in
11 Cornwall. So there's some information now that I think would
12 be available that the Government could make up its mind how to
13 handle this, and what its cost would be.

14 MRS. AYLEN: Would you be prepared to submit a
15 fee schedule for these drugs?

16 DR. SAWYER: That would be the Retail Pharma-
17 cists' Association.

18 MRS. AYLEN: And you say, in Item 147 ---

19 DR. ATKINSON: Mr. Chairman, this is something
20 that we can't document.

21 DR. GALLOWAY: I didn't hear anything about the
22 supplementary brief. Is it being discussed at this moment, or
23 is this being deferred?

24 Are you people prepared to answer questions on
25 it?



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would handle drugs, we haven't any recommendation at this time
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fee schedule for these drugs?

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Are you people prepared to answer questions on



1 DR. ATKINSON: Mr. Chairman, we have the
2 Chairman of the Section of Ophthalmology, Dr. Ballantyne,
3 and Dr. Freshmount, who is an ophthalmologist in the City
4 of Toronto, present, and questions concerning ophthalmology
5 could be directed to them.

6 DR. GALLOWAY: To start with, I wouldn't
7 want you to be under the impression that any question I'm
8 going to ask isn't loaded.

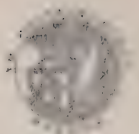
9 On page 11, in paragraph 35, you've made
10 reference to the payment of specialists' fees and referral.

11 I wonder if you would explain a little
12 further.

13 DR. BRUCE-LOCKHART: Dr. Galloway, as I'm
14 sure you know, this is a very complicated subject.

15 The first thing is the present pattern of
16 practice in the province is for many specialists to see
17 patients not on referral.

18 Then the next question arises: what's the best
19
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patients not on referral.

Then the next question arises: what's the best



1 thing in the long run for the practice of medicine, and it's
2 our feeling that the specialist who is to be the consultant,
3 that is to say who is to deal with the problems in his field,
4 if he spends half or three-quarters of his time, or whatever
5 proportion he does, on normal things that don't need specialist
6 care, he becomes of less value as a specialist, whereas the
7 specialist who devotes himself to the problems and gains
8 experience in the problems in his field, gains additional
9 value.

10 It's very difficult for a patient to make a
11 self-diagnosis, so he would quite probably go to the wrong
12 specialist first, and this puts up the cost, quite apart from
13 wasting time.

14 You have a certain percentage of the population
15 who go to family doctors, and who are referred to specialists
16 only when they require essentially specialist treatment. That
17 is to say, they are referred for procedures that require a
18 specialist's skill, or they are referred for an opinion on a
19 particular problem in the specialist's field.

20 Now, these patients will cost less premium-wise
21 than the patient who chooses to self-diagnose himself and to
22 go to the specialist directly.

23 Now, are you going to load the premium against
24 the man who is very happy with the general practitioner in order
25 that other people can go directly to specialists? If you do,



...in one form or another, and it is
...feeling that the specialist who is in the community,
...is no one who is not with the problem in the field.
...it is a matter of time - perhaps of his time, or perhaps
...in some cases, in some things that don't need specialist
care, he becomes of less value as a specialist, whereas the
specialist who devotes himself to the problems and gains
experience in the problem in his field, gains additional
value.

It's very difficult for a patient to make a
self-diagnosis, so he would quite probably go to the wrong
specialist first, and this takes up his time, and he is
wasting time.

You have a certain percentage of the population
who go to family doctors, and who are referred to specialists
only when they require something that is beyond the family
doctor's skill, or they are referred for an opinion on a
particular problem in the specialist's field.

Now, these patients will cost less premium-wise
than the patient who chooses to self-diagnose himself and to
go to the specialist directly.
Now, are you going to load the premium against
the man who is very happy with the general practitioner in his
field, or are you going to load it against the specialist? If you do,



1 then you remove any responsibility from the patient for consi-
2 dering the economic side of it at all.

3 Then are you not going to get more and more
4 unnecessary use of specialists, and abuse of their time, and
5 less and less general practitioners, and end up in a much
6 worse situation?

7 I think this is essentially the problem. I
8 agree with what Dr. Galloway says. It may actually work hard-
9 ship on a particular person that made a good self-diagnosis,
10 but in the long run, we feel that this will be better economi-
11 cally, and make for better medicine.

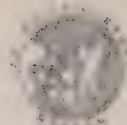
12 DR. GALLOWAY: You've spoken very well from the
13 standpoint of the doctor, but I'm still very concerned from
14 the standpoint of the patient who sees the specialist, and has
15 one or two choices.

16 One is to go right ahead and say there will be
17 a specialist fee and you will be responsible for the difference.

18 The other alternative he has is to refer this
19 patient back to a general practitioner to have the patient
20 referred back again. It seems unnecessary.

21 I go along with what you say, Dr. Bruce-Lockhart,
22 as being generally good, but the question, I believe, is right.
23 I'm not sure it's the pattern of practice that is at fault.

24 I wonder if you can tell me how many specialists
25 only see doctor-referred patients?



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1 from your records and responsibility from the patient for con-
2 sidering the economic side of it at all.
3 Then are you not going to get more and more
4 unnecessary use of specialists, and abuse of their time, and
5 less and less general practitioners, and end up in a much
6 worse situation?
7 I think this is essentially the problem. I
8 agree with what Dr. Galloway says. It may be a little bit
9 said on a particular point, but with a good self-discipline,
10 but in the long run, we feel that this will be better economi-
11 cally, and make for better medicine.
12 DR. GALLOWAY: You've spoken very well from the
13 standpoint of the patient, but I'm still very concerned from
14 the standpoint of the patient who has no specialist, and has
15 one or two choices.
16 One is to go right ahead and say there will be
17 a specialist fee and you will be responsible for the difference.
18 The other alternative he has is to refer this
19 patient over to a general practitioner to have the patient
20 referred back again. It seems unnecessary.
21 I go along with what you say, Dr. Bruce-Blackburn
22 as being essentially good, but the question I believe is raised
23 I'm not sure if the patient is prepared to do so.
24 I wonder if you can tell me how many specialists
25 only see doctor-referred patients?



3 1 DR. BRUCE-LOCKHART: You make the comment that
2 you don't think it's good for the patient. It's part of my
3 contention, sir, that what is good for medicine, the quality
4 of medical care, is good for the patient in the long run.

5 MR. SIMON: I've heard that slogan somewhere
6 before: "What's good for General Motors is good for the United
7 States."

8 DR. BRUCE-LOCKHART: That's not quite the
9 original that I heard, sir.

10 DR. GALLOWAY: I didn't believe that it was
11 necessarily the pattern of practice which is being followed
12 generally throughout the province, and I wondered if you could
13 give me any idea of the percentage of specialists who only
14 see patients who are doctor-referred?

15 DR. BRUCE-LOCKHART: We can't give you a specific
16 figure. We could give you this general impression, that
17 hitherto probably the majority of specialists have done a
18 considerable amount of unreferred work.

19 It's our impression that the last year, or
20 year-and-a-half, that there's increasingly a number of
21 specialists limiting themselves to referred work, and this
22 seems to be a trend that's developing.

23 It's creating another problem, in a sense,
24 because they're getting out of general practice, and we're
25 getting the shortage of general practitioners becoming more



DR. BRUCE-LOCKHART: You make the comment that

you don't think this is good for the patient. This part of it

concerns, sir, that there is some confusion, the matter

of medical care, is good for the patient in the long run.

MR. SIMON: I've heard that slogan somewhere

before. "What's good for the medical profession is good for the United

States."

DR. BRUCE-LOCKHART: That's not quite the

original that I heard, sir.

DR. GALLOWAY: I didn't believe that it was

exactly the same as the original which is being referred

to. I thought it was a variation, and I thought it was

give me any idea of the percentage of specialists who only

see patients who are doctor-referred?

DR. BRUCE-LOCKHART: We can't give you a specific

figure. We could give you this general impression, that

hitherto probably the majority of specialists have done a

considerable amount of unreferred work.

It is interesting to note that

year-and-a-half, that there's increasingly a number of

specialists limiting themselves to referred work, and this

seems to be a trend that's developing.

It's creating another problem, in a sense,

because they're getting out of general practice, and we're

creating the problem of general practice, and we're



1 acute.

2 DR. GALLOWAY: I wonder if I could refer this
3 question to the ophthalmologists, who undoubtedly are special-
4 ists in a very narrow field, but the ophthalmologists' brief --

5 THE CHAIRMAN: I owe everybody, I think, an
6 apology. As nearly as I can figure out, what must have
7 happened is that my secretary, who is very efficient as a
8 rule, apparently neglected to put this brief in with the rest
9 of the briefs that I have scheduled for the hearings here today,
10 and I had completely overlooked it, and made no arrangements
11 at all for any special study of this brief, aside from the
12 other briefs.

13 I don't know if any other members of our
14 Committee have overlooked this, too, or not.

15 MR. SIMON: I've had no chance to read it yet.

16 DR. GALLOWAY: Sir, in any event, I only have
17 one question to ask.

18 THE CHAIRMAN: I want you to ask that question,
19 anyway, but what I was going to ask here was, would it be
20 satisfactory if the members of our Enquiry study this, and
21 then, if we feel after discussion of it within the Enquiry
22 itself, we were satisfied that it is all right, we would let
23 it stand as that, with the brief as presented, or then, if
24 we do not feel that this is adequate, and there are questions
25 that we would ask on it, that we would invite you to meet with



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DR. GALLOWAY: I wonder if I could refer this

to the committee on the epidemiology of the disease.

It is in a very narrow field, but the epidemiology of the

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we do not feel that this is adequate, and then we would

that we would ask on it, that we would invite you to meet with



1 us at some future time to discuss it.

2 DR. ATKINSON: Yes, Mr. Chairman. Both the
3 Association and the members from the Section ---

4 THE CHAIRMAN: I'm sorry that this has happened
5 this way, but it's one of those things.

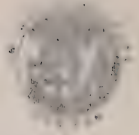
6 DR. GALLOWAY: I was only going to ask if the oph-
7 thalmologists could give us any figures as to the percentage
8 of patients who they see and treat who are doctor-referred.

9 DR. BALLANTYNE: We don't have any actual
10 figures, but from my own experience I would say that probably
11 80% of the patients we see are unreferred, and this is the
12 very reason we have a brief, and I might say, Mr. Chairman,
13 that one of the reasons we have a brief is that we are used to
14 being overlooked in medicine at times, and I think that because
15 of our specific field that it's very natural that most of our
16 patients will be making their own diagnoses.

17 DR. GALLOWAY: Well, I suspect this to be true,
18 and I wanted to have it on record. I could go on and ask some
19 other questions, but I think if you are going to come back we
20 would be very happy to ask them at a later time.

21 DR. BALLANTYNE: We would be very happy to
22 answer them now if they would fit the schedule, but we would
23 come back.

24 DR. GALLOWAY: Well, I'm wondering in what
25 situation will you handle the people who come in unreferred and



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answer them now if they would fit the schedule, but we would

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DR. GALLOWAY: Well, I'm wondering in what

of patients and the members from the Section ---



1 have an eye examination, and also during the course of this
2 have a refraction, if your recommendation is followed that
3 refractions not be covered under this Bill.

4 DR. BALLANTYNE: Mr. Chairman, our recommenda-
5 tion is that refractions, as an isolated procedure, not be
6 covered in the Bill.

7 Refraction is one of the procedures that we
8 might carry out in doing an eye examination, but we feel that
9 this is not a medical service, and not one that we would expect
10 people to have insured.

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tion is that refractions, as an isolated procedure, not be

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Refraction is one of the procedures that we

have covered in the Bill as eye examination, but we feel that

this is not a medical service, and we feel we should exempt

people to have insured.



/MR/dpw 1 DR. GALLOWAY: I am sure that the majority of your patients,
2 or even some of your patients come to you and say, "I haven't
3 had my eyes checked for three years." They have no particular
4 symptoms possibly of headache. "Is it due to my eyes?" What
5 are you going to do with these people in regard to charges
6 against the insuring companies under this Bill?

7 DR. BALLANTYNE: We feel that if the patient
8 deserves and needs a complete eye examination that this is
9 something that should be covered. If, however, they are
10 asking for a convenience, if they have broken their glasses
11 and want to have them checked before they get a new pair, if
12 they simply want to have an annual check, as we have discussed
13 when we are talking about annual physical examinations, that
14 is something that they can budget for. This is something that
15 can be determined other than by insuring against an unlikely
16 possibility so we do not feel that routine examinations
17 should be a part of that insurance contract. We do not feel
18 what we do as physicians is a routine refraction. We feel we
19 do a complete examination which is entirely related to the
20 field of medicine.

21 DR. GALLOWAY: You anticipate any problems in
22 dividing these people up as to which one should be charged
23 against the plan and which ones shouldn't?

24 DR. BALLANTYNE: Fortunately, this won't be our
25 problem. Our problem will be to deal with our patients as they



1 come and to indicate to either the insurance companies, the
2 carriers, as to what their problem was and what we did. If
3 we can indicate that what we have done is simply carrying out
4 refractions and nothing further, which is unlikely, but if
5 that were the case, we would not expect them to support the
6 patient. I know exactly what you are referring to. This is
7 again why we presented this brief. We knew there would be
8 some confusion and misunderstanding in this field and we hoped
9 that if we could impress you and our fellow physicians that we
10 are, in fact, dealing with disease, with eye problems not
11 related to simple errors in refraction, we have made a point.
12 This is our reason.

13 DR. GALLOWAY: Are you sufficiently familiar
14 with this paragraph that we spoke of of referrals? I would
15 take it your part of the Association is not in favour of this
16 paragraph No. 35 which recommends specialist fees be paid only
17 on referral of general practitioners?

18 DR. BALLANTYNE: We are in favour if the tariff
19 evolves that specialist fees will be paid if and when that
20 particular operation, that particular type of examination, is
21 not done by a general practitioner. We feel that this would
22 probably solve that particular problem. We know if this does
23 not occur probably we would just inflict a hardship on our
24 patients by insisting that they be referred - first contact
25 their general practitioner and then make their visit to us.



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patients by insisting that they be referred - that is what
their general practitioner and then make their visit to us.



1 We hope extending the specific nature of the type of work we
2 do this will not be necessary. People can, in our particular
3 field, be fairly accurate in diagnosing there is something
4 wrong with your eye and something which should be attended to.

5 DR. GALLOWAY: Thank you very much.

6 MR. CASWELL: Mr. Chairman, may I just ask a
7 question? Would you suggest that your fee will be broken down
8 into two sections, the refraction and the eye examination, and
9 that you would just be paid for the eye examination?

10 DR. BALLANTYNE: This was a suggestion, Mr.
11 Chairman, earlier on that this might be a way of answering
12 this particular problem. We do not feel that that is a prac-
13 tical answer at all. If you were doing one of the other
14 specialties such as the ear, nose and throat, and if you have
15 your hearing tested to see whether you need a hearing aid,
16 this is a separate procedure. I think we look upon refraction
17 as one of the many items that we do and which cannot be
18 isolated. In some instances, it may be a very small part of
19 the procedure. We don't like to apply a fee to that one
20 small portion of our examination.

21 MR. CASWELL: Coming back to Dr. Galloway's
22 question on the recommendation of the Medical Association you
23 would not be paid unless the patient went to the physician
24 first and then was referred to you on their recommendation ---

25 DR. BALLANTYNE: We would not be paid a



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We hope extending the specific nature of the type of work we do this will not be necessary. People can, in our particular field, be trained to do this work in a very short time.

DR. GALLOWAY: Thank you very much.

MR. CASWELL: Mr. Chairman, may I just ask a

question? Would you suggest that your fee will be broken down into two sections, the refraction and the eye examination, and that you would just be paid for the eye examination?

DR. BALLANTYNE: This was a suggestion, Mr.

Chairman, earlier on that this might be a way of answering this particular problem. We do not feel that that is a practical answer at all. If you were doing one of the other specialties such as the ear, nose and throat, and if you have your hearing tested to see whether you need a hearing aid,

this is a separate procedure. I think we look upon refraction as one of the many items that we do and which cannot be isolated. In some instances, it may be a very small part of the procedure. We don't like to apply a fee to that one small portion of our examination.

MR. CASWELL: Coming back to Dr. Galloway's question on the recommendation of the Medical Association you would not be paid unless the patient went to the physician first and then was referred to you on their recommendation -- DR. BALLANTYNE: We would not be paid a



1 specialist rate.

2 MR. MULROONEY: I would like to know, Doctor,
3 whether it is possible to do a refraction without examination
4 of the eye?

5 DR. BALLANTYNE: It is certainly possible to
6 do without a complete examination of the eye, yes. There are
7 many other items involved in assessing the health of one's
8 eye. There are many procedures.

9 MR. MULROONEY: Can you tell us whether opto-
10 metrists are trained to recognize disease of the eye? Do they
11 not commonly refer patients with disease to ophthalmologists?

12 DR. BALLANTYNE: There are a number of ques-
13 tions there. I think the one dealing with optometry I would
14 not be in a position to answer. I haven't any real knowledge
15 of their activities and as far as referrals are concerned, it
16 certainly is true that we see patients regularly who have
17 been previously seen by other doctors or optometrists or
18 other people: nurses, schools, and so on.

19 MR. MULROONEY: Thank you.

20 THE CHAIRMAN: I would like to ask a question,
21 sir. If a person comes to you and indicates he is interested
22 in nothing other than a refraction, would the ophthalmologist
23 normally perform more than a refraction or what would be done
24 normally by an optometrist, if you have sufficient knowledge
25 of what an optometrist would do?



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THE CHAIRMAN: I would like to ask a question,

sir. If a person comes to you and indicates he is interested

in nothing other than a refraction, would the ophthalmologist

normally by an optometrist, if you have sufficient knowledge

of what an optometrist would do?



1 DR. BALLANTYNE: Yes. I think when we are
2 asked, and we are asked, and this is the reason that we have
3 included this as an exclusion as physically we hope we are
4 dealing completely with their ocular problem that when we are
5 asked to do simply a refraction, when we are asked either by
6 industry to check someone for their safety glasses, or if we
7 are asked by the Licensing Bureau of the Department of Trans-
8 port to test one's vision for the driver's licence, we will do
9 this and we do it. Of course, we do not expect that to be
10 something they would pay insurance for, but if the patient
11 asks us to examine their eye and we do just a refraction, I
12 think it is not unfair to say most of us - probably all of us
13 would say that we have only done that and that we are not
14 taking responsibility for the health of their eye or their
15 body until we have done a complete examination and we would
16 ask them to come back, if time was a problem.

17 THE CHAIRMAN: If you were going to do a
18 complete examination you would likely ask them to come back a
19 second time rather than just the one visit?

20 DR. BALLANTYNE: It is not so much time. It is
21 sometimes the drugs that are necessary for the proper examina-
22 tion in dealing with the eye and the use of these drugs may
23 involve certain problems in terms of their ability to drive
24 their car home after the examination. It could be very likely
25 that we would be asking to see them again on another occasion.



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DR. BALLANTYNE: Yes. I think when we are asked to do simply a refraction, when we are asked either by industry to check someone for their safety glasses, or if we are asked to test one's vision for the driver's licence, we will do this and we do it. Of course, we do not expect that to be something they would pay insurance for, but if the patient asks us to examine their eye and we do just a refraction, I think it is not unfair to say most of us - probably all of us would say that we have only done that and that we are not taking responsibility for the health of their eye or their body until we have done a complete examination and we would ask them to come back, if time was a problem.

THE CHAIRMAN: If you were going to do a second time rather than just the one visit?

DR. BALLANTYNE: It is not so much time. It is in fact in dealing with the eye and the use of these drugs may involve certain problems in terms of their ability to drive their car home after the examination. It could be very likely



1 THE CHAIRMAN: I had my eyes examined by both an
2 optometrist and ophthalmologist and had glasses prescribed by
3 the latter and purchased glasses from the former and the fee,
4 as I recall, is the same in both cases, and the procedure
5 followed was, as far as I could see to a layman, was the same
6 in both cases.

7 Now, I do not think it was any more serious
8 than that my glasses were not making me see quite as well as
9 I could previously and the only change was a change in pres-
10 cription. Under those circumstances, I remember the ophthal-
11 mologist who examined my eye just did the ordinary refraction.
12 Would that be right?

13 DR. BALLANTYNE: I would hope that is wrong, Mr.
14 Chairman. I hope if he be an ophthalmologist he would do more
15 than a simple refraction. I would be surprised if he did not.

16 THE CHAIRMAN: Then you would think in most
17 cases a person who goes there would, in the opinion of the
18 ophthalmologist, be eligible for a charge beyond that of
19 refraction. The ophthalmologist does more than refraction.
20 The refraction becomes part of his examination and, therefore,
21 merits a charge even if the refraction were not included in the
22 Bill?

23 DR. BALLANTYNE: Indeed.

24 THE CHAIRMAN: So that if refractions were not
25 included in there, a good many cases all that would be required



THE CHAIRMAN: I had my eyes examined by both an optometrist and an ophthalmologist and was pleased by the results and was able to see from the front and the back as I recall, in the same in both cases, and the procedure followed was, as far as I could see to a layman, was the same in both cases.

Now, I do not think it was any more serious than a case of glaucoma which was treated as well as I recall, probably and the only danger was a change in pressure. When I was examined, I remember the doctor said that my pressure was just about the ordinary pressure. Would that be right?

THE CHAIRMAN: I would have said in your case, Mr. Chairman, I hope if he be an ophthalmologist he would do more than a simple refraction. I would be surprised if he did not.

THE CHAIRMAN: Then you would think in most cases a person who goes there would, in the opinion of the ophthalmologist, be able to see a change in his refraction. The ophthalmologist does more than refraction. The refraction is given at his examination and therefore, a change in his refraction would be a change in his vision. Bill?

THE CHAIRMAN: So that if refractions were not taken in this, a good many cases all that would be required



1 would be refractions but the patient, in your opinion, would
2 receive more and be eligible?

3 DR. BALLANTYNE: That is correct.

4 THE CHAIRMAN: Any further questions?

5 DR. GALLOWAY: I have one or two more, if I
6 can. I don't know how long you plan to sit here. This won't
7 be too long. One of the questions that I would like to ask
8 is in relation to the ophthalmologists' final recommendation,
9 with government being asked to increase grants to medical
10 schools, research programs, et cetera. Was it your idea in
11 presenting this brief to us that the insurance plan should in
12 some way make contributions towards this?

13 DR. BALLANTYNE: Not directly. We felt that
14 the whole problem of eye care was one in which the history
15 has shown that the physician has been playing an increasing
16 role since the establishment of these courses in ophthalmology.
17 If we are going to be able to grow in this aspect of the
18 physician's problem that we did not need continuing support;
19 we are very proud of the progress that has been made in our
20 specialty. We feel if we are going to be able to deal with the
21 province as a whole and be able to supply things that are
22 needed we will have to have support. We do not think that
23 support comes from insurance companies but we think that the
24 problem should be examined and understood. This, we hope,
25 will serve that purpose.



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1 would be interested in the question, in your opinion, would

2 receive more and be eligible?

3 DR. BALLANTYNE: That is correct.

4 THE CHAIRMAN: Any further questions?

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6 can. I don't know how long you plan to sit here. This won't

7 be too long. One of the questions that I would like to ask

8 is in relation to the question of the role of the

9 with respect to the role of the

10 research program, as outlined in your report.

11 I am asking this question to see how the research program

12 some way make contributions towards this?

13 DR. BALLANTYNE: Not directly. We felt that

14 the whole problem of eye care was one in which the history

15 has shown that the physician has been playing an increasing

16 role since the establishment of these courses in ophthalmology.

17 If we are going to be able to grow in this aspect of the

18 program, a program that is

19 we are very proud of the progress that has been made in our

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22 needed we will have to have support. We do not think that

23 support comes from insurance companies but we think that the

24 problem should be examined and understood. This, we hope,

25 will serve that purpose.



1 DR. GALLOWAY: The other things I have, sir,
2 are asking this organization or association if they would be
3 willing to make comments on some of the recommendations which
2 4 have been made to us. As far as I am concerned they are under
5 no obligation to comment on these unless they feel free to do
6 so.

7 It has been suggested that no change be made
8 in the Ontario Medical Association schedule of fees without
9 the approval of some committee yet to be formed where there
10 would be members of government, insuring agencies and other
11 representatives of the public; presumably labour groups
12 present.

13 Do you agree to this change in schedule? Do
14 you wish to make any comment on this seeing as you are directly
15 concerned?

16 DR. BRUCE-LOCKHART: I think the answer to that,
17 really, is in the medical profession you are dealing primarily,
18 in the majority of cases, with self-employed people. It is
19 not customary nor economic for self-employed people to have to
20 negotiate a schedule. Secondly, we make a schedule - this is
21 coming back to an earlier discussion, really - as a guide,
22 realizing there are varying problems all over the province.
23 We did not wish insurance on the situation. Insurance has
24 appeared, and it is a very good thing. I don't want you to
25 think I am objecting to it but it does bring certain



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DR. GALLOWAY: The other things I have, sir,

the feeling that the association is not doing enough to help the public. As far as I am concerned they are under no obligation to comment on these unless they feel free to do so.

It has been suggested that no change be made in the Ontario Medical Association schedule of fees without the approval of some committee. I am not sure whether this would be members of government, insurance agencies and other representatives of the public; presumably labour groups.

Do you agree to this change in schedule? Do

DR. BRUCE-LOCKHART: I think the answer to that,

in the majority of cases, with self-employed people. It is not customary nor economic for self-employed people to have to pay a fee. I think, generally, we have a tendency to come back to an earlier discussion, really - as a guide, realizing there are varying problems all over the province. We did not wish insurance on the situation. Insurance has appeared, and it is a very good thing. I don't want you to think I am objecting to it but it does bring certain



1 complications with it which is this average fee in which we
2 believe, to a very great extent, provided we are not completely
3 tied to it. The moment you get into a suggested negotiation -
4 in other words, you cannot change the fee without approval of
5 a committee, it means you have to negotiate, as Mr. Simon says,
6 a bargaining situation, you change this whole concept.

7 DR. GALLOWAY: You would be opposed?

8 DR. BRUCE-LOCKHART: Yes.

9 MR. SIMON: You have got me at a disadvantage.
10 I am getting hungry.

11 DR. GALLOWAY: There are two other things. I
12 will read them to you and you can decide if you wish to make
13 any comments on the recommendation we have received that other
14 carriers should have the right to pro-rate physicians' accounts.
15 We have been urged to encourage group practice. Has your
16 Association any comments on the advantage or disadvantage of
17 these recommendations?

18 DR. ATKINSON: Mr. Chairman, the first question:
19 there is no recommendation concerning pro-ration in our brief.
20 The Association's policy in relation to Bill 163 stated that
21 we should not pro-rate the fees. That was a discussion earlier
22 this afternoon. We discussed the base of the doctor-sponsored
23 plans and recognized physicians have the right to make arrange-
24 ments to accept a fee different than the full fee of the
25 schedule but as to a statement of policy, the question of



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will read them to you and you can decide if you wish to make

any comment on the recommendations as they relate to the

carriers should have the right to pro-rate physicians' accounts

We have been urged to encourage group practice. Has your

Association any comments on the advantage or disadvantage of

these recommendations?

DR. ATKINSON: Mr. Chairman, the first question

is the recommendation to pro-rate accounts in our field.

The Association's policy in relation to Bill 163 stated that

we should not pro-rate accounts. There was a discussion earlier

this afternoon. We discussed the case of the dentists

and we agreed that dentists have the right to have accounts

to accept a fee different than the full fee of the

dentists and as to a statement of policy, the question is

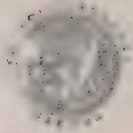


1 pro-ration is no.

2 The question of group practice, perhaps,
3 should be commented on by Dr. Bruce-Lockhart. Before he
4 does that, there is a section of group practice outlined in
5 the brief to the Royal Commission on Health Services.

6 DR. BRUCE-LOCKHART: I think your question was
7 whether there was some pressure to encourage group practice.
8 Is this a good thing? I think the first thing that we should
9 be made aware of is group practice is a very vague term, sort
10 of a broad generic term, and it runs the gamut from a situa-
11 tion where a group of doctors merely combine together to
12 provide office space and have good relationship to each other,
13 otherwise a partnership, a loose arrangement between doctors.
14 There are at times, in a sense, group practice clinics where
15 the earnings are shared, run by doctors, and clinics where the
16 earnings are shared, run by lay organizations, and such advanced
17 things as the Mayo Clinic.

18 When we talk about group practice, we are
19 talking about a tremendous range of things. In general, there
20 are certain advantages to group practice. One is, of course,
21 that overheads are lessened. It is, therefore, easier to
22 provide, to some extent, better facilities. Perhaps ten,
23 twelve doctors together can get an x-ray, worthwhile getting
24 a radiologist in, and x-ray. There is some definite advantages
25 in this area.



protection is no.

The question of group practice, perhaps,

should be considered by the Commission. Before we

does that, there is a section of group practice outlined in

the brief to the Royal Commission on Health Services.

DR. BRUCE-LOCKHART: I think your question was

whether there are some people in some group practice

is this a good thing? I think the first thing that we should

be this kind of a group practice is a very young man, and

it is a group practice, and it runs the same from a group

the same a group of doctors really working together to

provide better care and have good relationships to each other,

especially in a group, a group of doctors, and a group of doctors,

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that overheads are lessened. It is, therefore, easier to

provide, to some extent, better facilities. Perhaps ten,

the same doctors together can do a lot of work, and the same

a radiologist in and out, there is some definite advantage

in this area.



1 There are other advantages, such as ease of
2 consultation if there are specialists there. The advantages
3 of association between doctors in comparing notes and discus-
4 sing problems, and so on. Some very real advantages in that
5 area there, and then again, from the doctors' point of view,
6 there is an advantage in that it is easier to arrange time off.
7 From the patients' point of view there is the advantage that
8 it is usually good coverage at odd hours, weekends, and that
9 type of thing. I think these are the advantages of group
10 practice.

11 At the same time, there are certain disadvan-
12 tages. I think the biggest one is it tends to be impersonal
13 unless you are very careful; certainly tends to be impersonal
14 if the group gets at all large. It is quite difficult for
15 continuity of care. Patients cannot always see the same
16 doctor and this tends to get a little lost. It is not very
17 easy to control the size of the group. You may start out at a
18 good manageable size; somehow a little bit like Topsy it tends
19 to grow. It may be hard to control. The bigger it is the
20 harder it is to keep personal touch with the individual. In
21 fact, there is a bit of tendency to refer only within the
22 group and to an extent, therefore, you are limiting the choice
23 of consultants, particularly to the patient. It may not be as
24 overt as that but certainly a tendency that way. The same way
25 it seems to be quite difficult to get doctors to settle down



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There are other advantages, such as ease of
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of association between doctors in a specialty is a very real advantage in that
and problems, and so on. Some very real advantages in that
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to grow. It may be hard to control. The bigger it is the
harder it is to keep personal touch with the individual. In
fact, there is a bit of tendency to refer only within the
group and to the hospital. There are limitations on the
of specialists, particularly in the hospital. It may not be as
easy as it used to be, but it is certainly a tendency that way. The same way
it seems to be quite difficult to get doctors to settle down



1 together and as a result - this is probably more on the junior
2 staff - there is a tendency in many, many groups for the junior
3 staff to move through and this makes the continuity of care we
4 were talking about harder. It does not seem to suit everybody.

5 I think, to sum it up, we would say that it is
6 an effective way of practice. That it tends to be impersonal
7 and that it suits some types of people, talking about patients.
8 It suits some types of doctors. It suits some situations, but
9 it is not, by any means, the answer to everything.

10 DR. GALLOWAY: Thank you very much.

11 THE CHAIRMAN: Are there any more questions
12 from the members of the Enquiry? I would like to just correct
13 one statement I made when I referred to the Secretary. I was
14 not referring to our very able Secretary here who is acting as
15 Secretary for the Enquiry. It was my personal secretary. Do
16 you have any further comments?

17 DR. ATKINSON: Mr. Chairman, I would like to
18 express the thanks of the Association for the courtesy that
19 has been extended to us here. It has been a lengthy session
20 but I hope that we have been of some assistance to you and the
21 members of the Enquiry. If there are further areas that you
22 would wish us to make comment and recommendations on, I would
23 request, sir, that this be submitted to us in writing so that
24 we would have the area and problems delineated for our consi-
25 deration.



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would wish us to make comment and recommendations on, I would
request, sir, that this be submitted to us in writing so that
we would have some time and would be able to make the necessary



1 Again, thank you very much.

2 THE CHAIRMAN: I am quite confident, speaking
3 for the lay members of the Enquiry, it has been very enlight-
4 ening to us.

5 MR. DREWRY: Before you adjourn, I wonder if
6 I might be permitted to correct an error in our discussion
7 this morning. I only suggest doing so because Mr. Major
8 referred to the same thing this afternoon and that is when Dr.
9 Emmett was describing the psychiatric benefit in Alberta, he
10 referred to a limitation of one day per month. That was not
11 correct. It was a slip of the tongue. There is a twelve-
12 month waiting period and that is the only limitation.

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14 --- Adjournment.

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